NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

Congressional Information Service, Inc
Washington D.C.

[COMMITTEE PRINT]

99th Congress
2d Session | HOUSE OF REPRESENTATIVES

A REPORT ON THE ACTIVITIES

OF THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

U.S. HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

together with

DISSENTING MINORITY VIEWS

1986

Printed for the use of the
Select Committee on Children, Youth, and Families

U.S. GOVERNMENT PRINTING OFFICE

58-957 O WASHINGTON : 1986

H962-5

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC, 20402

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

GEORGE MILLER, California, *Chairman*

WILLIAM LEHMAN, Florida
PATRICIA SCHROEDER, Colorado
LINDY BOGGS, Louisiana
MATTHEW F. McHUGH, New York
TED WEISS, New York
BERYL ANTHONY, JR., Arkansas
BARBARA BOXER, California
SANDER M. LEVIN, Michigan
BRUCE A. MORRISON, Connecticut
J. ROY ROWLAND, Georgia
GERRY SIKORSKI, Minnesota
ALAN WHEAT, Missouri
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois

DAN COATS, Indiana
HAMILTON FISH, JR., New York
THOMAS J. BLILEY, JR., Virginia
FRANK R. WOLF, Virginia
DAN BURTON, Indiana
NANCY L. JOHNSON, Connecticut
JOHN R. McKERNAN, JR., Maine
BARBARA F. VUCANOVICH, Nevada
DAVID S. MONSON, Utah
ROBERT C. SMITH, New Hampshire

COMMITTEE STAFF

ALAN J. STONE, *Staff Director and Counsel*
ANN ROSEWATER, *Deputy Staff Director*
MARK SOUDER, *Minority Staff Director*

CONTENTS

	Page
Membership	1
Summary of 1985 activities	2
Hearings conducted	2
Sites visited	3
Reports issued	3
Committee hearing summaries and fact sheets	4
Alcohol Abuse and its Implications for Families (March 18, 1985)	4
Families with Disabled Chidren: Issues for the 80's (April 19, 1985)	9
Tax Policy: What do Families Need (April 24, 1985)	15
Prevention of Alcohol Abuse in American Families (May 2, 1985)	20
Emerging Trends in Mental Health Care for Adolescents (June 6, 1985)	25
Learning from the Private Sector: A Dialogue with Foundation Executives (June 27, 1985)	31
Child Care: The Emerging Insurance Crisis (July 18, 1985).	36
Child Care: The Emerging Insurance Crisis, Part II (July 30, 1985)	36
Melting Pot: Fact or Fiction (September 26, 1985)	42
Child Victims of Exploitation (October 31, 1985)	48
Children and Families in Poverty: Beyond the Statistics (November 6, 1985)	53
Sudden Infant Death Syndrome (November 14, 1985)	58
List of witnesses and those who submitted testimony for the record, 1985	63
Excerpts from selected reports	69
Opportunities for Success: Cost-Effective Programs for Children	70
Tax Policy: How Do Families Fare?	75
Teen Pregnancy: What Is Being Done? A State-By-State Look	79
Summary of 1983 and 1984 activities	118
Hearings conducted	118
Sites visited	119
Reports issued	120
Dissenting Minority Views of Hon. Dan Coats, Ranking Minority Member; Hon. Hamilton Fish, Jr.; Hon. Thomas J. Bliley, Jr.; Hon. Frank R. Wolf; Hon. Dan Burton; Hon. Nancy L. Johnson; Hon. Barbara V. Vucanovich; Hon. David S. Monson; and Hon. Robert C. Smith	122

MEMBERSHIP

The Select Committee on Children, Youth, and Families during the First Session of the 99th Congress included 25 members, each of whom served on the Full Committee and one or two of the Committee's three task forces. The members are listed below:

FULL COMMITTEE

GEORGE MILLER, California, Chairman

WILLIAM LEHMAN, Florida
PATRICIA SCHROEDER, Colorado
LINDY (MRS. HALE) BOGGS, Louisiana
MATTHEW F. McHUGH, New York
TED WEISS, New York
BERYL ANTHONY, JR., Arkansas
BARBARA BOXER, California
SANDER M. LEVIN, Michigan
BRUCE A. MORRISON, Connecticut
J. ROY ROWLAND, Georgia
GERRY SIKORSKI, Minnesota
ALAN WHEAT, Missouri
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois

DAN COATS, Indiana, Ranking Minority
HAMILTON FISH, JR., New York
THOMAS J. BLILEY, JR., Virginia
FRANK R. WOLF, Virginia
DAN BURTON, Indiana
NANCY L. JOHNSON, Connecticut
JOHN R. McKERNAN, JR., Maine
BARBARA F. VUCANOVICH, Nevada
DAVID S. MONSON, Utah
ROBERT C. SMITH, New Hampshire

TASK FORCES

TASK FORCE ON PREVENTION STRATEGIES

WILLIAM LEHMAN, Chairman
THOMAS J. BLILEY, JR., Ranking Minority

TASK FORCE ON CRISIS INTERVENTION

LINDY (MRS. HALE) BOGGS, Chair
DAN BURTON, Ranking Minority

TASK FORCE ON ECONOMIC SECURITY

PATRICIA SCHROEDER, Chair
FRANK R. WOLF, Ranking Minority

SUMMARY OF 1985 ACTIVITIES

Following is a list of the activities conducted by the Select Committee on Children, Youth, and Families during the calendar year 1985. Following the list are summaries of the major findings of each hearing, their corresponding fact sheets, and excerpts from three of the reports issued.

HEARINGS CONDUCTED

Alcohol Abuse and Its Implications for Families
(Prevention Strategies and Crisis Intervention Task Forces)
Washington, D.C.

Families with Disabled Children: Issues for the 80's
Field Hearing - Anaheim, CA

Tax Policy: What do Families Need?
(Economic Security Task Force)
Washington, D.C.

Prevention of Alcohol Abuse in American Families
(Prevention Strategies and Crisis Intervention Task Forces)
Washington, D.C.

Emerging Trends in Mental Health Care for Adolescents
Washington, D.C.

Learning From the Private Sector: A Dialogue with Foundation Executives
Washington, D.C.

Child Care: The Emerging Insurance Crisis
Washington, D.C.

Child Care: The Emerging Insurance Crisis, Part II
Washington, D.C.

Melting Pot: Fact or Fiction?
Washington, D.C.

Child Victims of Exploitation
(Prevention Strategies and Crisis Intervention Task Forces)
Washington, D.C.

Children and Families in Poverty: Beyond the Statistics
Washington, D.C.

Joint Hearings

Sudden Infant Death Syndrome
(Jointly held with the Subcommittee on Census and Population of the Committee on Post Office and Civil Service, and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce)
Washington, D.C.

SITES VISITED

Friendship House

Washington, D.C. This community center provides a broad range of services and programs directed at the economically disadvantaged. These services include educational programs for children ages 2 to 14, services for the elderly, a Psycho-Social Unit, a Youth Unit, a Consumer Action Unit, and an Energy Unit. The center also provides free meals and free clothing for those in need.

REPORTS ISSUED

Opportunities For Success: Cost Effective Programs For Children - This bipartisan staff report shows how eight programs for children and youth have improved the lives of the participating children, and saved public monies as well. The report includes an annotated bibliography of relevant research. The highlighted programs include: WIC, Prenatal Care, Medicaid, Childhood Immunization, Preschool Education, Compensatory Education, Education For All Handicapped Children (P.L. 94-142), and Youth Employment and Training.

A Family Tax Report Card - This bipartisan staff report compares seven critical family tax issues as treated under current law, Kemp/Kasten, Bradley/Gephardt, and Treasury II. The report evaluates how each tax proposal affects the following seven major family-related questions: (1) which proposals make it less costly to have children; (2) which provide the most relief to single parents; (3) which reduce taxes for low-income working families; (4) which have the lowest overall rates for the average family; (5) which have the least marriage penalty; (6) which provide the most support for child care expenses; (7) which treat one-earner and two-earner families most fairly? The best grades are given to those propsals which ensure families of equal size and equal income pay equal taxes, which are most progressive, and which result in the fewest tax disparities as a result of being married.

Tax Policy: How do Families Fare? - This bipartisan report is a compilation of eight papers by various tax analysts which review significant tax issues affecting families. Included are a review of the effect of tax reform on low-income families, the disparities in taxes paid by different kinds of families, and the changes in family tax burdens over time.

A Family Tax Report Card: Round II - This staff analysis is a follow-up comparison of the tax reform proposals now before Congress. Using the same seven criteria as the first report, this report analyzes current law, Kemp/Kasten, Bradley/Gephardt, Treasury II, and the recently introduced reform package approved by the House of Representatives Committee on Ways and Means.

Teen Pregnancy: What Is Being Done? A State-By-State Look - The Select Committee developed and sent to every state a survey regarding teenage pregnancy. This Committee report is a compilation and analysis of the data received from the states. Included are a look at national perspectives on adolescent pregnancy and parenting, barriers to serving at-risk, pregnant and parenting teens, Federal policies and programs, and state efforts presently serving at-risk, pregnant and parenting teenagers.

SUMMARY OF PREVENTION STRATEGIES AND CRISIS INTERVENTION TASK FORCES HEARING ON "ALCOHOL ABUSE AND ITS IMPLICATIONS FOR FAMILIES" WASHINGTON, D.C., MARCH 18, 1985

On March 18, 1985, the Crisis Intervention and Prevention Strategies Task Forces of the Select Committee on Children, Youth, and Families held a joint hearing on the subject, "Alcohol Abuse and Its Implications for Families." This topic was chosen for the first Committee hearing of the 99th Congress because alcohol abuse seemed to be connected to, or to exacerbate, many problems facing families that the Committee learned about during the 98th Congress. The hearing was designed to begin an investigation of these connections.

The first panel of witnesses consisted of members of families who had experienced problems with alcohol abuse. Mrs. Dot West and her 21 year old son, Bret, from Baton Rouge, Louisiana, described how their family deteriorated under the stress of having three teenage sons addicted to alcohol and drugs. Efforts by Mrs. West, a public school teacher, and her husband, a businessman, to control their son's behavior failed. Traditional counseling efforts also failed. A previously close-knit, church-going family was reduced to constant conflict until help for the entire family was obtained through a local, publicly funded substance abuse treatment center. All three sons have now overcome their addiction and are attending a local university.

Similar stories of the progressive loss of control caused by alcohol and drug addiction were shared by Marjorie of Montgomery County, Maryland, a 36 year old mother of two daughters, and Mrs. Beverly Faria of Concord, California, a 28 year old mother of three. Marjorie connected her chaotic and lonely childhood in an alcoholic home with her own addiction, as an adult, to alcohol and Valium and to her daughter's problem drinking at age 13. Today, with help from substance abuse therapists and Alcoholics Anonymous, Marjorie, her daughter and her parents no longer abuse alcohol and drugs.

Mrs. Faria described how her problem drinking interfered with her ability to care for her preschool age children, resulting in intervention by a local child protective services agency. She described the dilemma facing many substance abusing single parents -- since many residential substance abuse treatment centers do not accommodate children, in order to get well, parents must give up their children to foster care.

Dr. Ian Macdonald, Chief Administrator of The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) led the second panel, followed by Judge Albert L. Kramer, Presiding Justice, Quincy District Court, Massachusetts, and Judge Andy Devine, Lucas County Court of Common Place, Juvenile Division, Toledo, Ohio. Dr. Macdonald reviewed the statistics on problem drinking, which indicate that alcohol abuse directly affects 13-14 million Americans, costs society $116 billion a year, and is associated with high rates of marital dysfunction, family violence, and a range of disorders in young children and adolescents. He also indicated that treatment for alcohol abuse works, and that it is less costly to provide treatment than not to.

Judge Kramer, reviewing statistics on the connection of problem drinking to many of the problems he sees in his courtroom, stated that alcohol abuse was the single most important issue facing courts today.

He has, accordingly, organized his court to provide comprehensive evaluation of all suspected problem drinkers, and includes treatment as part of sentencing procedure.

In response to information that 13,000 juveniles in the Toledo community were heavy users of alcohol or marijuana, Judge Devine organized and implemented a community-wide effort to address the problem. Schools, hospitals, churches, police, mental health services, and parents are involved in this cross-county effort, with the juvenile court serving as the neutral convenor.

A researcher, two administrators, and a representative of a parent self-help group completed the final panel. Dr. Sheila Blume, Medical Director of the Alcoholism and Compulsive Gambling Programs at South Oaks Hospital, Amityville, New York, and Member of The Board of Directors, Children of Alcoholics Foundation, Inc., New York, shared results of a recently published review of the literature on children of alcoholics. She noted that recent research strongly indicates alcoholism is, in part, an inherited problem, suggesting the importance of targeting "at-risk" individuals. The report estimates that 28.6 million individuals are children of alcoholics. Dr. Blume stressed that while our knowledge about substance abuse has made striking gains, treatment services are not reaching the vast majority of individuals who need them. Mr. John Daigle, Executive Director of The Florida Alcohol and Drug Abuse Association, and Vice Chairperson of The Governor's Commission on Drug and Alcohol Concerns, described the Commission's findings. A high percentage of various social problems such as child abuse, homicide and other crimes, and job absenteeism are related to substance abuse. In response, the Commission has recommended, and the state is inaugurating, statewide prevention, early intervention, and treatment programs involving parents, schools, religious, business, and media organizations. John Bland, Director of Maryland's Alcoholism Control Administration stressed the importance of comprehensive treatment for problem drinkers. He stated that, to be effective, treatment must involve the entire family.

Ms. Carolyn Burns, Vice President of The National Federation of Parents for Drug Free Youth (NFP), Silver Spring, Maryland, also stressed the need to involve the entire family in treatment of a substance abusing individual, as family members may adopt harmful behavior that can perpetuate the problem. NFP provides technical assistance, resource materials, and advice, to nearly 9,000 parent groups across the country.

ALCOHOL ABUSE AND ITS IMPLICATIONS FOR FAMILIES
A FACT SHEET

EXTENT OF THE PROBLEM

* 10% of the U.S. population engages in problem drinking. (NIAAA, 1979)

* 1 out of every 8 Americans -- 28 million children -- are children of problem drinkers; nearly 7 million are children under age 18. (Children of Alcoholics Foundation, Inc., 1985)

* One-out-of-three to one-out-of-six respondents state drinking has been a cause of trouble in his or her family. (Gallup, 1979-84).

* 69% of high school seniors have used alcohol in the past month; one in 18 use alcohol daily; 41% had five or more drinks in a row at least once in the past two weeks. (NIDA, 1984)

* Alcohol abuse and dependence is the most common psychiatric disorder among men; among the most common disorders for women. (NIMH, 1980-82)

ECONOMIC COSTS

* Alcohol abuse cost the nation $89.5 billion in 1980. (Research Triangle Institute; 1984)

* Diminished work productivity resulting from alcohol abuse accounted for $50 billion of the cost in 1980. (Research Triangle Institute, 1984)

* The economic costs of alcohol and drug abuse are over four times that of cancer and nearly three times greater than cardiovascular diseases. (NIDA, 1984)

PROBLEMS FOR FAMILIES

Separation and Divorce

* The separation and divorce rate among alcoholics and their spouses is seven times greater than for the general population. (DHHS, 1983)

* 33 to 40% of intact alcoholic couples are estimated to have poor marital relationships. (DHHS, 1983)

Family Violence

* 40% of all family court problems involve alcoholism. (DHHS, 1983)

* Alcoholism is involved in 50% of the cases of spouse abuse. (DHHS, 1983)

* Many studies report a connection between child abuse and neglect and alcoholism. (Children of Alcoholics Foundation, Inc., 1985)

PROBLEMS FOR INFANTS, YOUNG CHILDREN, AND TEENAGERS

* Babies born to alcoholic mothers are at high risk for Fetal Alcohol Syndrome (FAS) -- a recognized pattern of congenital malformations. (Ouellette, Eunice Kennedy Shriver Center, 1983)

* Each year 3,700 to 7,400 U.S. babies are born with FAS; an additional 11,000 to 18,500 babies are born with fetal alcohol effects. (Ouellette, Eunice Kennedy Shriver Center, 1983)

* FAS is the third most common cause of mental retardation. (Ouellette, Eunice Kennedy Shriver Center, 1983)

* Parental drinking is associated with learning problems, hyperactivity, social aggression, increased anxiety, psychosomatic complaints, and low self-esteem in young children. (Children of Alcoholics Foundation, Inc., 1985)

* Motor vehicle accidents are the leading cause of death for persons aged 15 to 24. (DHHS, 1983)

* The 16 to 24 year old age group accounts for 41% of all single vehicle accident fatalities and 45% of all single vehicle fatal accidents involving alcohol. (DHHS, 1983)

* 28% of runaway youths in a Rochester, New York shelter came from alcoholic homes. (Center for Youth Services, Rochester New York, 1984)

* 44% of boys and 47% of girls in New York City runaway shelters stated their parents used alcohol or drugs excessively. (Report to the Ittleson Foundation, 1984)

* Parental drinking is associated with eating disorders, truancy, delinquency and substance abuse in teenagers. (Children of Alcoholics Foundation, Inc., 1985)

OTHER PROBLEMS

Accidents

* Alcohol is estimated to be responsible for approximately 25,000, or 50% of all highway fatalities annually; 14-32% of airplane fatalities; 34-62% of drownings; 30-54% of deaths from fire, and 21-48% of deaths due to falls. (NIAAA, 1982)

Crime

* 31 to 70% of those arrested for violent crimes (homicide, physical or sexual assault) had been drinking when the crime was committed. 45-64% of homicide and physical assault victims had also consumed alcohol. (NIAAA, 1982)

* In 1979, 33% of all state prison inmates surveyed reported drinking heavily just before committing the offense for which they were convicted. 33% said they drank daily the year before incarceration, and 66% of these stated they drank very heavily. (Department of Justice, 1983)

Depression

* At some time while drinking, 33-50% of alcoholics display symptoms of clinical depression. (Children of Alcoholics, Inc., 1985)

Suicide

* Alcohol is a factor in 20-37% of completed suicides; suicide attempters are 4 to 6 times more likely than the general population to report being problem drinkers or alcoholics. (DHHS, 1983)

NIAAA -- National Institute of Alcohol Abuse and Alcoholism
NIDA -- National Institute of Drug Abuse
NIMH -- National Institute of Mental Health
DHHS -- Department of Health and Human Services

SUMMARY OF FULL COMMITTEE FIELD HEARING ON "FAMILIES WITH DISABLED CHILDREN: ISSUES FOR THE 80'S" ANAHEIM, CALIFORNIA, APRIL 19, 1985

Families with disabled or chronically-ill children face many of the same stresses other families do. They do, however, experience circumstances and choices that other families do not. Family stress may become more pronounced if there are no support services or other available resources.

The Committee convened a hearing, in conjunction with the Council for Exceptional Children's Annual Convention in Anaheim, California, to better understand the nature and extent to which families with disabled children are experiencing stress and to learn about successful programs and policies designed to respond to their needs.

Beverly Bertaina, from Sebastopol, California, is the mother of Adam, a 12 year old boy with multiple handicapping conditions. She described the obstacles she faces daily in trying to integrate her son into school, the community, recreational activities and child care. She also shared her personal concerns regarding the stress brought on by the current expense of keeping Adam at home, the lack of respite care, and the few acceptable choices which are available for Adam's future.

Mary Short, from Fountain Valley, California, is a single parent of a five year old daughter who has Tuberous Sclerosis, a severe handicapping condition. Short was forced to place her daughter in a "board and care home" primarily because full-time child care and respite services were unavailable. Lack of enforcement of the child support payments she was due factored in her decision to place her child out-of-home. In her view, now that her daughter is no longer living at home, all health care and support services required by her daughter are paid for.

Lisbeth Vincent, Associate Professor in the Department of Studies in Behavioral Disabilities at the University of Wisconsin-Madison, based on her work with families with young disabled children, described the pressures faced by these families which center around how much time, energy and resources they have to devote to the child's problem. These are, she added, often in addition to the prevalent stresses faced by all American families today -- single and teenage parenthood, increasing incidence of poverty and child abuse, and growing concern about alcohol and drug use.

Unfortunately, the early intervention services which could provide real support for these families are not available in most communities. Even with The Education for All Handicapped Children's Act (P.L. 94-142), only 25 percent of the estimated one million preschool-age handicapped children who need special education services are receiving them. Vincent recommended mandating state and local educational agency responsibility for the handicapped child's educational program from the time the child is diagnosed.

Advocating for more active decision-making by families, Vincent also described the Wisconsin Family Support Program which provides financial assistance to families who are facing the institutionalization of their child, to help them purchase the individualized services which would allow their child to remain at home.

Much of what Vincent said about families with young disabled children was corroborated by Ann Turnbull, Acting Associate Director of the Bureau of Child Research at the University of Kansas, Lawrence. Turnbull, primarily addressing the needs of families with disabled adolescents, emphasized the tremendous need these families have for social supports, and described how, with some educational efforts, churches and the volunteer sector can be used to help enhance the social support network. Professional services, as well as personal spiritual beliefs also can help families cope. She pointed out the need to develop intervention strategies for assisting families in their decisions, as well as the need for a constant public funding stream and greater opportunities for community-based residential and vocational services.

John Butler, Principal Investigator for the Collaborative Study of Children with Special Needs, The Children's Hospital Medical Center, Boston, highlighted the major findings of a 1983 survey involving 1,750 children from the elementary school special education programs of five of the nation's largest school systems. He found significant proportions of children in special education living below the federal poverty line and in single-parent families, compounding family stress. Forty percent of the families reported that they changed the way they lived, where they were employed, and how they cared for their children, because of their child's disability.

Only 9% of the families participated in any form of parent group, and only three-fifths said they had an adequate familiarity with community services for their children. Many children in the survey sample were at risk of receiving limited health care, because they had no regular source of health care, no regular physician, or no public or private health insurance. Butler concluded by stating that while much greater coordination and involvement among health, education, and social services is necessary, P.L. 94-142 remains among the most important national commitments to children, and deserves to be strengthened and reinforced.

The second panel began with Stephen Brees from Fullerton, California, who has cerebral palsy. He shared aspects of his educational, economic, and employment experiences with Committee members. Brees remained in segregated schooling for the disabled until the age of 16. With the support of a teacher and his family, Brees transferred to a "regular" educational curriculum in a mainstreamed high school setting. Now, Brees has a Masters Degree in Psychology and is a consultant to the Fountain Valley School District in California. He attributes his current success in living independently to the challenges he faced and the confidence he built in the mainstreamed educational setting.

Finding and training personal attendants, who help him with fundamental tasks such as personal hygiene and dressing, remain among his greatest difficulties in continuing to live independently. Lack of affordable and safe transportation is another barrier. He must also be able to earn enough money to pay for the cost of personal attendants ($400-$500 per month). For most disabled individuals, the only option is remaining on public assistance (Supplemental Security Income and Medicaid).

When early intervention programs for disabled infants and toddlers are available, the services are traditionally provided one to three times a week for several hours each session. Trudy Latzko, Program Director of the Developmental Services Department of Family Service

Agency of San Francisco described for the Committee a unique full-day mainstreamed child care program for disabled and non-disabled infants and toddlers, including infants with medical disabilities who would not be served by any other program. This program serves primarily high-risk (low-income, teen-parent, or Spanish-speaking) families who would not be able to benefit from part-day programs because they must work.

The program is therapeutic and has helped many infants with handicapping conditions enter mainstreamed preschool settings at age 3. In addition, the program provides continuous support services and counseling for the parents.

Florene Poyadue, parent of a nine-year-old with Down's Syndrome and Executive Director of Parents Helping Parents, San Jose, California, and Martha Ziegler, also a parent and Director of the Federation for Children with Special Needs, Boston, described their efforts to provide training, information, and support to parents of disabled children. They also discussed the importance of improving communication between parents and professionals in the medical and educational arenas.

Poyadue discussed the principal issues raised by the parents she works with, including discipline for a disabled child who is often inappropriately punished in the classroom; misclassification and misplacement of learning disabled children; and the need for support for siblings.

Ziegler, on behalf of Betsy Anderson, Director of Health Services at the Federation, made the important point that providing home-care for children with serious medical needs remains a difficult task. In addition, chronically-ill children are still excluded from health insurance coverage, and suffer still from the many misunderstandings about the responsibility of the school system to serve chronically-ill children under P.L. 94-142.

FAMILIES WITH DISABLED CHILDREN
A FACT SHEET

HOW MANY CHRONICALLY ILL AND DISABLED CHILDREN ARE THERE?*

-- A widely accepted estimate of the prevalence of handicaps in the population under age 21 is 11.4% (9.5 to 10 million children). (Kakalik, 1973)

-- Over two million children, double the number since 1958-61, suffer some degree of limitation of their activities because of their health or disability. (Newacheck, Budetti, and McManus, 1984)

-- Just over one million children (1.5% of the childhood population) are limited in their ability to attend school. (Newacheck, Budetti, and McManus, 1984)

-- Another 9 million have less severe chronic illnesses. (Vanderbilt Institute for Public Policy Studies, 1983)

STRESSES THAT CHALLENGE FAMILY STABILITY

-- Families with a disabled child are about twice as likely to experience divorce or separation. (Breslau, unpublished, 1985; Bristol, 1984)

-- Nearly 20% of children with cerebral palsy seen over a twelve-month period at one Chicago care center had been abused. (Diamond and Jaudes, 1983)

-- In 1980, respite care was the need most frequently identified by state social services for families with developmentally disabled children. (Cohen and Warren, 1985)

PREVENTION SAVES MONEY AND KEEPS FAMILIES TOGETHER

-- In-home care for a severely disabled child costs $7,000 to $8,000 per year, compared to $38,000 to $40,000 annually for institutionalizing that child. (Disability Rights Education and Defense Fund, 1984; Vincent, 1985)

-- If intervention for handicapped infants is delayed until age six, education costs to age 18 are estimated at $53,350. If intervention services begin at birth, education costs are estimated at $37,272. Total savings: $16,078. (U.S. Dept. of Education, 1985)

* Who is defined as handicapped or disabled may include those within a broad range: those with mild mental retardation or learning disabilities to those with hearing impairments, visual impairments, severe physical disabilities, multiple handicaps or chronic illness. Depending on the definitions used, estimates of the percentage of children with disablities may range from 4% to 24% of the childhood population. (The Children's Policy Research Project, 1980) Estimates of the numbers of handicapped children are highly unsatisfactory because many children are incorrectly classified as handicapped; others possess undetected disabilities. (Gleidman and Roth, 1980)

-- For every $1 invested in high quality preschool programming, there is a $3 reduction in public special education costs. (Schweinhart and Weikert, 1980)

-- A Colorado study which analyzed the cost-effectiveness of a quality preschool program found a cost savings of $2,000 per pupil in averted special education services. (Weiss, 1981)

HANDICAPPED CHILDREN: IN OR OUT OF SCHOOL?

-- Although as many as 10 million children are estimated to have handicaps and may need special education services, in 1983-84, 4,341,399 handicapped children, ages 3-21, were served under the Education of the Handicapped Act. (U.S. Dept. of Education, 1985)

-- Almost half the children served were identified as "learning disabled"; and the increase in the learning disability category (from 797,213 in school year 1976-77 to 1,811,489 in 1983-84) accounted for the greatest proportion of the total increase in children served since 1976-77. (U.S. Dept. of Education, 1985)

-- It is estimated that 1 million preschool-age handicapped children need special education services. However, in 1983-84 only 243,087 3-5 year olds received services under P.L. 94-142, barely an increase from the 232,000 children served in 1975. (U.S. Dept. of Education, 1985; Vincent, 1985)

FINDING A JOB: FEW OPPORTUNITIES FOR DISABLED YOUTH

-- Many disabled students graduate from the regular educational curriculum. Another 250,000 to 300,000 disabled students leave or graduate from special education each year. And, in Colorado, 50% of special education graduates participated in postsecondary education at some time in the 4 to 7 years following graduation. (U.S. Dept. of Education, 1984 and 1985)

-- Nevertheless, between 50%-80% of working-age disabled adults (6 to 10 million persons) are jobless. Those for whom publicly supported day and vocational services are available often experience low wages, slow movement toward employment, and segregation from their non-disabled peers. (U.S. Dept. of Education, 1984)

-- Between 50%-60% of former special education students are employed. However, among more severely handicapped students in the State of Washington, only 21% were employed. Even for more mildly handicapped youth, almost all jobs were in part-time, entry-level service positions. A Colorado study found that special education graduates were earning at or below minimum wage. (U.S. Dept. of Education citing three studies, 1985)

MEETING THE COST OF HEALTH CARE

-- Forty percent of all disabled children in poverty are ineligible for Medicaid. (Vanderbilt Institute for Public Policy Studies, 1983)

-- Estimated average expenditures for health services for chronically ill or disabled children may be 10 times as high as for non-disabled children ($3,200 compared to $300 per year in 1978 dollars). (Breslau, 1984)

-- While 68% of all children receive health benefits under group plans, many costs faced by families with chronically-ill or disabled children are not covered. Many families are excluded from participation by private insurers because of refusal to cover pre-existing conditions. (Vanderbilt Institute for Public Policy Studies, 1983)

-- In a random sample of children with disabilities in five of the largest school systems, a significant percentage had no regular source of health care, no regular physician, or no public or private health insurance. (Butler, 1984)

SUMMARY OF ECONOMIC SECURITY TASK FORCE HEARING ON "TAX POLICY: WHAT DO FAMILIES NEED?" WASHINGTON, D.C., APRIL 24, 1985

On April 24, 1985, the Economic Security Task Force held a hearing entitled: "Tax Policy: What do Families Need?" This hearing grew from the Select Committee's recommendation, resulting from its child care initiative last year, for a comprehensive review of how tax policies affect famlies.

The hearing served to identify those tax provisions which most affect families, how they work, and how they help or hurt various families. In addition, the hearing provided analyses of the various comprehensive tax reform proposals now before Congress, from the perspective of their effects on children and families, and surfaced ways to change tax policy to make it more fair for faimlies.

Senator Daniel Patrick Moynihan, (D-NY), was our first witness. Senator Moynihan described how, unlike five years ago, working families who are at poverty level and below now pay taxes. He also noted that the greatest change in the tax treatment of families has been the erosion over time of the personal exemption, which in 1948 exempted 42 percent of average per capita personal income.

The Senator contrasted the economic status of children with that of the elderly. Because of government policies and programs, only 3% of people 65 or over are now poor. However, 32% of children born in 1980 will be on Aid to Families with Dependent Children (AFDC) sometime during their childhood. Children are six times more likely to be living in poverty than the elderly.

Fifty percent of children will live with one parent during their childhood (another witness later cited a newly revised statistic -- 70% of children will live in one parent homes). Such children are even more likely to live in poverty. Since we are a country that values self-sufficiency, according to the Senator, we should not be taxing the poverty level income of their parents, driving them futher into poverty.

A panel of three witnesses then testified, Robert Carleson, a former Assistant to President Reagan for Policy Development, who is now director of government relations for an international consulting firm, discussed the Earned Income Tax Credit (EITC). The EITC is a refundable credit which assists low-income families who have children, and who have earned income. The effect of the credit is to provide a refund of a portion of the Social Security payroll tax assessed on the low-income earner's wages. Mr. Carlson called for an expansion of the EITC to provide relief from the payroll tax. He recommended that the percentge of the EITC should be raised to match the current combined employee-employer Social Security tax (about 14.5%), and indexed. Additional credit should be allowed based on the number of children in the family. In addition, Mr. Carleson proposed that the level of income which a family can earn before income tax is assessed be raised and indexed.

Joseph Minarik, a Senior Research Associate at the Urban Institute, Washington, D.C., described the basic framework of the individual income tax law that applies to working families. He described certain items currently excluded from income, such as employer-paid fringe benefits, and interest on whole life insurance. However, he pointed out that other taxpayers without such benefits are penalized because their cash-only income is fully taxed.

Minarik then described two elements of the tax code which affect the majority of families: the personal exemption and the zero bracket amount. Families are entitled to a personal exemption of $1,000 for each person in their tax unit. Due to inflation, the value of the exemption has eroded, particularly harming low-income families. The zero bracket amount (formerly called the standard deduction) affects those families who do not itemize. Increases in the zero bracket amount would provide a tax cut to all non-itemizers, but, according to Minarik, lower-income taxpayers, most of whom do not itemize, would benefit most.

There are two tax credits that apply most directly to families. The credit for child and dependent care expenses applies to expenses for child care or for care of an elderly or handicapped dependent, incurred so that a taxpayer ca work. The earned income tax credit benefits low-income working families with children. Because its value has been eroded by inflation, however, the effectiveness of the EITC in assisting these families has diminished. Also, not all families eligible for the credit apply for it.

Alvin Schorr, Professor of Family and Child Welfare at Case Western Reserve University, Cleveland, Ohio, addressed ways to ensure that poor working families are treated fairly by the tax code. He called for a new tax credit, "The Refundable Tax Credit," which would absorb the existing earned income tax credit and eliminate the present $1,000 personal exemption. Instead, his proposal would provide a $400 tax credit for each member of a family. Total credits would be reduced by 5 percent of household's adjusted gross income in excess of $10,000. Individuals owing no taxes would be entitled to refunds of the credit.

The last witness was Marian Wright Edelman, President of the Children's Defense Fund (CDF), Washington, D.C. Based on CDF's recently published study, "The Impact of Federal Taxes on Poor Families," she described how taxes on the poor and near poor have increased substantially in the past few years. In her view, poor and near-poor families should not be subject to income tax or excessive Social Security tax.

Ms. Edelman indicated that while the major tax reform proposals begin with the premise that the poor should not be subject to income tax, each of the plans fails to bring low-income families even to their 1979 tax status. CDF has included several tax provisions in their omnibus Children's Survival Bill. These include proposals to index the Earned Income Tax Credit (EITC) for inflation; expand eligibility for the EITC; add a dependent allowance to the EITC; increase the zero bracket amount; adjust the zero bracket amounts for single working parents; and make the dependent care credit refundable.

TAX POLICY: WHAT DO FAMILIES NEED?
A FACT SHEET

ECONOMIC SUPPORTS FOR CHILDREN HAVE ERODED

* If the personal exemption, the primary means by which the tax code adjusts for family size, had been indexed for inflation since 1948, ($600 then) it would be worth over $2,600. It is currently $1,000.

* In 1950, a two parent family of four earning $5,800 (the equivalent of $25,000 in 1984 dollars) paid $197 or 3.4% of their income in federal income taxes. (CRS, 1985)

* In 1984, a similar family earning $25,000 paid $2,679 or 10.7% of their income in federal income taxes, an increase of 215% in the percentage of income paid in income taxes. (CRS, 1985)

* The Social Security payroll tax, a flat-rate tax on earnings, has more than doubled since 1960, from 3% to over 7% in 1985. (CDF, 1985)

LOW-INCOME FAMILIES ARE LOSING GROUND

* Between 1975 - 1980, a family of four with poverty level income paid no income taxes. In 1984, a four person family earning $8,783, more than $1,800 below the poverty line ($10,613 for a family of four), paid income taxes, as did a family of six earning $9,719, $4,500 below the poverty line ($14,219 for a family of six). (JCT, 1984)

* In 1978, a family of four at the poverty line paid $403 in payroll taxes and received $134 in refundable Earned Income Tax Credits for a total federal tax burden of $269. In 1984, a similar low-income family paid $711 in payroll taxes and $365 in income taxes for a total federal tax burden of $1,076, an increase of 300%. (JCT, 1984)

* Despite legislative changes in 1984, the real value of the Earned Income Tax Credit, the primary tax-related work incentive for low-income families, is below its 1982 level and will continue to decline after 1985 because it is not indexed for inflation. (W&M, 1985)

* Between 1972 and 1984, the average total real income of a working poor single mother of three, including poverty level wages, AFDC, Food Stamps and federal tax benefits or expenditures, declined by over 22%, from $13,361 to $10,372 in 1984 dollars (W&M, 1985)

TAX BURDENS ARE NOT EVENLY DISTRIBUTED AMONG FAMILIES

* Between 1966 and 1985, total federal, state and local taxes paid by the poorest one-tenth of the population rose from 17% of their income to 22%, while all taxes for the wealthiest tenth dropped from 40% to 25.5%. (Pechman, Brookings Institution, 1985)

* Changes in federal tax laws in 1981 and 1982 provided average tax reductions for families with incomes under $10,000 of $70 between 1983 and 1985. The average gain for families earning between $40,000 and $80,000 was $9,060, and for families earning $80,000 and over, the average gain was $24,600. (CBO, 1984)

* In 1982, nearly 70% of the 5 million families claiming the Dependent Care Credit had adjusted gross incomes above $20,000. Only 6% of all families claiming the credit had incomes below $10,000 and less than 5% of the estimated $1.5 billion in credits went to these families. (IRS, 1984)

* Since 1960, the percentage of total federal revenue raised through income and payroll taxes on individuals and families has increased from 59.9% to 80.7% in 1984, while the percentage of revenues raised through corporate taxes has declined from 23.2% to 8.5%. (Citizens for Tax Justice, 1985)

FAMILIES OF EQUAL SIZE AND INCOME RECEIVE DIFFERENT TAX TREATMENT

* In 1984, a single parent of three school-aged children earning $25,000 paid $3,212 in income taxes, assuming no child care expenses were claimed. Because the zero bracket amount (standard deduction) is lower for single heads of households than it is for married couples, and because tax rate schedules differ for these two groups, a married, single-earner couple with two children earning the same $25,000 paid $2,679 in income taxes, $533 or 17% less than the single parent. (CRS, 1985)

* In 1984, a one-earner married couple with two children earning $25,000 paid $2,679 in federal income taxes. A two-earner family that claimed the maximum dependent care credit (unavailable to one-earner families) and the deduction for working couples paid $1,356 in income taxes on $25,000 in earnings, $1,323 or 49% less than the one-earner couple. (CRS, 1985)

FAMILY INCOME DECLINES, CHILD-REARING COSTS REMAIN HIGH

* A median income family of four in which the mother works part-time will spend $82,400 (in 1981 prices) to raise a child to age 18, an average of nearly $4,600 per child per year. (Espenshade, Urban Institute, 1985)

* Over the past five years, median family income has declined by over 9% in real terms, from $26,885 in 1979 to $24,580 in 1983. (Census Bureau, 1984)

* In 1981, the USDA estimated a moderate standard of living for a family of four to be $25,400. At that time, the average industrial wage was $13,270, 52% of the income necessary for a moderate standard of living. (Schorr, Case Western Reserve University, 1984)

* Between 1980 and 1983, American families lost $323 billion in income (in 1982 dollars after accounting for taxes and transfers) averaging $3,837 per family -- due largely to unemployment. (Sawhill, Urban Institute, 1984)

WOMEN ARE WORKING TO SUPPORT FAMILIES

* Since 1960, the percentage of families with both the husband and wife in the labor force nearly doubled, from 25.5% to 49% In 1984, more than 50% of all working wives had husbands who earned less than $20,000. (Census Bureau and BLS, 1984)

* The number of female headed families has increased from 4.4 million in 1960 to 9.5 million in 1983. Nearly half of all single mothers with children work, and nearly half of all female-headed families with children are poor. (Census Bureau and BLS, 1984)

BLS -- Bureau of Labor Statistics
CBO -- Congressional Budget Office
CDF -- Children's Defense Fund
CRS -- Congressional Research Service
IRS -- Internal Revenue Service
JCT -- Joint Committee on Taxation
W&M -- Committee on Ways and Means

SUMMARY OF PREVENTION STRATEGIES AND CRISIS INTERVENTION TASK FORCES HEARING ON "PREVENTION OF ALCOHOL ABUSE IN AMERICAN FAMILIES" WASHINGTON, D.C., MAY 2, 1985

The Crisis Intervention and Prevention Strategies Task Forces held a joint hearing on May 2, 1985, on the topic, "Prevention of Alcohol Abuse in American Families." The hearing was a follow-up to the March 18 hearing on "Alcohol Abuse and Its Implications for Families."

The first panel consisted of two witnesses, Mr. James F. Mosher, Associate Director for Policy Studies, Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California, and Mr. Alfred Regnery, Administrator, Office of Juvenile Justice and Delinquency Prevention, Department of Justice.

Altering the environment which surrounds young people, rather than relying solely on education programs, is the key to successful prevention programs, according to Mr. Mosher. Describing the special circumstances of youthful drinkers, he noted that advertising of alcohol beverages frequently targets youth, and that today, beer is often price-competitive with soft drinks, because federal and state excise tax rates have effectively declined 28% over the past 30 years. Citing studies which show that tax increases on alcoholic beverages reduce consumption -- especially among the young -- Mr. Mosher recommended that Congress increase the federal excise tax on all alcoholic beverages and equalize taxes, according to alcohol content, on wine, beer, and distilled spirits.

Mr. Regnery briefly described the "National Partnership to Prevent Drug and Alcohol Abuse," which is sponsored by the Office of Juvenile Justice and Delinquency Prevention. The effort seeks to coordinate existing private sector initiatives to address substance abuse among young people, rather than initiate or replicate successful programs to address the problem.

The second panel was led by Mr. Tim Reid, actor and co-star of the CBS television series, Simon and Simon, and Board Director of the Entertainment Industries Council (EIC), in McLean, Virginia. Mr. Reid described efforts by EIC, the Caucus for Producers, Writers, and Directors, and other entertainment industry groups to "deglamorize" portrayal of drugs and alcohol in advertising, motion pictures, and television. Recent efforts include a proposal to establish a new movie rating, "S.A." (substance abuse), to warn parents that a film contains considerable drug and alcohol portrayal.

Michael Jacobson, Executive Director of the Center for Science in the Public Interest, Washington, D.C., followed Mr. Reid with a dramatic presentation of the extent to which today's college student is inundated with advertising and marketing messages sponsored by the beer industry. Dressed in a Budweiser T-shirt and cap, he displayed dorm posters featuring beer and sex and success themes and a large "We're No.1!" sign, complete with beer brand name, for use at athletic events. He played radio ads and showed TV ads for beer, each of which featured sports and rock star figures. Dr. Jacobson asserted that the alcohol industry spends $2 billion per year in efforts to indoctrinate people, especially young people, into a lifestyle in which alcohol plays the central role. In contrast, a small amount is spent by the industry on public education efforts. He recommended banning all advertising aimed at youth and heavy drinkers, and stepping up public education messages to equal the time now spent promoting drinking.

Augustus Hewlett, President of the Alcohol Policy Council, Waterford, Virginia, and representing the National Association of Broadcasters, stated that the increasing acceptance in the U.S. of the attitude that alcoholism is a disease deserving treatment, not punishment, is the major reason for signficant progress in coaxing problem drinkers "out of the closet." He stressed that continued public and school-based education is the appropriate prevention solution and that "control" approaches to alcohol availability will fail and will frighten alcoholics back into hiding.

Mr. John Burcham, Chairman of the Licensed Beverage Information Council (LBIC), which represents the alcholic beverage industry, reported on the many public service efforts LBIC has sponsored. Examples included participation in the DHHS sponsored "Healthy Mothers, Healthy Babies" campaign which includes efforts to increase awareness about fetal alcohol effects.

The third panel consisted of witnesses representing school-based and community-based prevention programs.

Mayor Howard E. Duvall of Cheraw, South Carolina, described how he organized, with other community leaders in this small rural community, a four-part approach to address youth substance abuse, following the deaths of three teenagers in three months due to drunk driving. Police surveillance and enforcement of drunk driving laws were stepped up, with start-up funds from the state. Schools tightened rules concerning student mobility and set behavior standards for students seeking leadership positions and athletic opportunities. A Parent Commission, later given permanent status by Mayor Duvall, organized seminars in substance abuse awareness, parenting skills, and other subjects. As a result, a consensus among participating parents was reached concerning the serving of alcohol in homes, curfews, and increased PTA involvement. A recreation committee is seeking to provide constructive alternatives to "keg parties" in abandoned cabins. The committee convinced a restaurant franchise attractive to teenagers to locate in the town, and is also seeking funds to build a teen center. Cheraw has not had an alcohol related youth fatality since this comprehensive program began two years ago.

Members next heard from Ms. Doreen Sanders, Student Assistance Counselor, Westchester County, New York. Ms. Sanders described how the Student Assistance Program, through a series of school-based counselors, reaches out to high school students who are substance abusers, children of alcoholics, and those who are exhibiting school behavior problems. The program has had a 70% success rate in preventing students from using alcohol, a 94% success rate in preventing marijuana use, a 63% success rate in stopping alcohol use, and a 94% success rate in stopping marijuana use.

Ms. Sanders was accompanied by Constance Kaplan (a pseudonym), a 16 year old Westchester County student. Ms. Kaplan described her experiences being raised by an alcoholic father, including instances of sexual abuse. Ms. Kaplan was helped by the Student Assistance Program to regain self-esteem, and stressed the importance of having a confidential counselor at school eliminating the need to find hard to arrange transportation, or gain parental permission - which are frequent barriers to participation in Alateen and mental health clinic programs.

Ms. Sue Rusche, Executive Director of Families in Action, based in Atlanta, Georgia, described the focus and efforts of her parent-founded

organization which seeks to ensure that laws addressing drug and alcohol abuse are enforced. Established in 1977, Families in Action was responsible for passing the nation's first drug paraphenalia law in Georgia, which became the basis for the Model Drug Paraphenalia Act passed by Congress in 1979. Their current efforts focus on ensuring those selling or serving alcohol to minors are held liable. Ms. Rusche criticized organizations like SADD (Students Against Driving Drunk), which function under the premise that minors may become intoxicated and, if so, should be prevented from driving by friends and family.

The final witness was Ms. Sis Wenger, Alcohol and Drug Consultant, Henry Ford Hospital MAPLEGROVE, in Birmingham, Michigan. Ms. Wenger stressed the importance of involving parents as a key prevention method. She described one intensive training program for volunteers, which is designed to heighten awareness of community groups and schools. She noted the strong connection between alcohol and drug abuse and a host of serious problems families face, including separation and divorce, family violence, child sexual abuse, running away behavior of teenagers, as well as teen suicide.

PREVENTION OF ALCOHOL ABUSE IN AMERICAN FAMILIES
A FACT SHEET

ALCOHOL ABUSE IS WIDESPREAD

* 10% of the U.S. population engages in problem drinking. (NIAAA, 1979)

* 1 out of every 8 Americans -- 28 million children -- are children of problem drinkers; nearly 7 million are children under age 18. (Children of Alcoholics Foundation, Inc., 1985)

* One out of every three to one out of every six respondents identify drinking as a cause of trouble in his or her family. (Gallup, 1979-84)

* Among high school seniors, 69% have used alcohol in the past month; one in 18 use alcohol daily; 41% had five or more drinks in a row at least once in the past two weeks. (NIDA, 1984)

* 25% of fourth graders say that children in their age group feel "some" or "a lot" of peer pressure to try beer, wine, liquor, or marijuana. By 7th grade, 60% feel pressure to try alcohol. (Weekly Reader, 1983)

* Even TV programming emphasizes alcohol use. A 1980 study found 8.13 incidents of alcohol consumption per hour on the 10 top-rated prime time series. (National Academy of Sciences, 1984)

HEALTH AND ECONOMIC COSTS OF ALCOHOL ABUSE ARE GROWING

* Alcohol abuse cost the nation $116.7 billion in 1983. (Research Triangle Institute, 1984)

* Diminished work productivity resulting from alcohol abuse accounted for $65.5 billion of the cost in 1983. Associated health care accounted for $14.9 billion. (Research Triangle Institute, 1984)

* The economic costs of alcohol and drug abuse are over four times greater than cardiovascular diseases. (NIDA, 1984)

* Chronic brain injury caused by alcohol is second only to Alzheimer's disease as a known cause of mental deterioration in adults; pancreatic cancer is twice as frequent in alcoholics, and alcohol is a factor in cancers of the liver, stomach, and other digestive tract organs; alcoholic cirrhosis of the liver causes 11,000 U.S. deaths annually. (DHHS, 1983)

* Each year 3,700-7,400 U.S. babies are born with Fetal Alcohol Syndrome. FAS is the third most common cause of mental retardation. (Ouellette, Eunice Kennedy Shriver Center, 1983)

FEDERAL EFFORTS TO ADDRESS THE PROBLEM ARE DECLINING

Total Expenditures Are Down

* While alcohol abuse costs the nation $89.5 billion in 1980, only $1.3 billion from all public, private and third-party sources was spent to combat the problem -- a 69 to 1 ratio. 45%, or $585

million of that amount was from federal sources. (Research Triangle Institute, 1984; NIAAA, 1984)

* The only law which assured any federally-assisted prevention or treatment services for alcohol and drug abusers was the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act. Between 1980-84, federal funds for these services were reduced in real terms by 43%, and folded into the Alcohol, Drug Abuse and Mental Health Services Block Grant. All previous reporting requirements under the Act have been eliminated. (NASADAD, 1984)

Prevention Efforts Are Relatively Small

* From 1980 through 1984, NIAAA spent an average of 7-8% of its total budget on prevention research and other prevention activities. (NIAAA, 1985)

* The National Association of State Alcohol and Drug Abuse Directors, Inc. have estimated that, in 1984, states spent 11.5% of total available public and private funds on efforts to prevent alcohol and drug abuse while, in contrast, spending 80% on treatment programs -- a 7 to 1 ratio. (NASADAD, 1984)

* Altogether, in 1984, the states, NIAAA, and the Department of Education spent approximately $83 million on a variety of alcohol prevention efforts while the alcoholic beverage industry spent over $1 billion on advertising alone to promote drinking -- a 12 to 1 ratio. (NASADAD, 1984; National Academy of Sciences, 1984)

STUDIES SHOW PREVENTION EFFORTS WORK

* 2-5 times more New York City 7th graders, who participated in a 20-session alcohol prevention program, reported they drank less or no alcohol, compared with students who did not participate in the program. (Botvin, Journal of Alcohol Studies, 1984)

* A student assistance program in New York's Westchester County schools has had a 70% success rate in preventing high school students from using alcohol, a 94% success rate in preventing marijuana use, a 63% success rate in stopping alcohol use, and a 94% success rate in stopping marijuana use. (New York State Division of Alcoholism and Alcohol Abuse, 1984)

* Each year, 30,000 people in the U.S. die from cirrhosis of the liver. A 1981 study of state excise taxes on alcoholic beverages found a $1 tax increase per proof gallon of liquor averted 500 deaths from cirrhosis of the liver. (National Academy of Sciences, 1984)

* Advertising bans, drunk driving laws and higher taxes instituted by the Swedish government resulted in a 21% decrease in per capita consumption between 1976 and 1982 and a 12% decline in heavy drinking among 16 year old boys. (Swedish Council for Information on Alcohol and Other Drugs, 1982)

NASADAD -- National Association of State Alcohol and Drug Abuse Directors
NIAAA -- National Institute of Alcohol Abuse and Alcoholism
NIDA -- National Institute of Drug Abuse
NIMH -- National Institute of Mental Health
DHHS -- Department of Health and Human Services

SUMMARY OF FULL COMMITTEE HEARING ON "EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS" WASHINGTON, D.C., JUNE 6, 1985

Following two earlier hearings on alcohol abuse and its implications for families, on June 6, 1985, the Select Committee on Children, Youth, and Families held a hearing which looked closely at trends in available treatment for youngsters with emotional and substance abuse problems.

The first panel began with the testimony of Ira Schwartz, Senior Fellow, Hubert H. Humphrey Institute of Public Affairs, University of Minnesota.

Mr. Schwartz testified that an increasing number of juveniles are being institutionalized for chemical dependency and psychiatric treatment in private hospitals and free standing residential facilities, and that this trend is linked to the availability of third party health insurance reimbursement. He noted that, nationwide, juvenile admissions to private psychiatric hospitals increased 450% between 1980 and 1984, and in Minnesota, juvenile admissions to psychiatric units in general medical hospitals doubled between 1976 and 1984.

Many of these admissions may be unnecessary and costly, according to Mr. Schwartz, and, in Minnesota, result from an excess of hospital beds, and mandatory state insurance laws which require coverage for in-patient mental health and chemical dependency treatment.

Committee Members next heard from Barbara DeFoe, a parent from Coon Rapids, Minnesota, and her 15 year old daughter, Marissa.

Mrs. DeFoe described Marissa's experience, one year earlier, when she was unnecessarily admitted to a secure adolescent psychiatric unit. Concerned about Marissa's inability to sleep for two nights following a stressful event, Mrs. DeFoe had arranged to have Marissa seen by their new pediatrician. The pediatrician, without seeing Marissa, scheduled an evaluation at a local hospital emergency unit. After Marissa and Mrs. DeFoe talked with a social worker, admission, which was covered by Mrs. DeFoe's health insurance, was recommended. Although shocked at this drastic step, Mrs. DeFoe said she was assured Marissa would get a hospital bed, a sedative, and an opportunity to talk with trained counselors.

Instead, Marissa was admitted to a locked psychiatric ward. When she refused to take oral medication, she was placed in isolation and forcibly injected with Haldol -- a drug to control psychosis. It took eight days, with the assistance of a patient advocate, to secure Marissa's release. When Marissa was later evaluated by a community-based mental health clinician, Mrs. DeFoe was told Marissa was a normal teenager experiencing normal stress, who should not have been hospitalized and did not even require outpatient counseling.

Marissa corroborated her mother's testimony. After several days of Haldol injections, which she consistently resisted, Marissa reported a variety of physical effects caused by the drug injections -- especially loss of bladder control and drooling.

One year later, Marissa reports that she is doing well. She has resumed her place on her school's honor roll, track team, and participates in church activities.

Dr. James Egan, Chairman, Department of Psychiatry, Children's Hospital National Medical Center in Washington, D.C. concluded this panel.

Dr. Egan reiterated that psychiatric admissions for adolescents have increased but reports that this is a result of more impaired adolescents. He stated the high divorce rate is probably a contributing factor. He also stated that when less intensive treatment alternatives are not available, such as therapeutic foster homes, and group homes, a more intensive and costly level of care will be employed.

The American Psychiatric Association (APA) currently runs peer review programs for third party insurers to assess, both concurrently and retrospectively, appropriateness of psychiatric inpatient care. In addition, Dr. Egan stated that the APA is developing guidelines for pre-admission review of the appropriateness of inpatient care in psychiatric units.

The second panel began with Mark Schlesinger, Ph.D., Research Coordinator, Center for Health Policy and Management, John F. Kennedy School of Government, Harvard University.

Dr. Schlesinger told committee members that the mental health care system (for both children and adults) is currently undergoing a period of commercialization: the number of psychiatric hospitals under proprietary ownership has increased more than 150% in the past 15 years; nearly one-third of residential facilities for the mentally ill and institutions specializing in the treatment of substance abuse are under for-profit ownership; as of 1982, two-thirds of the for-profit psychiatric beds were controlled by the five largest multi-hospital chains.

Dr. Schlesinger also noted that states are increasingly mandating insurance coverage for psychiatric and substance abuse treatment -- particularly inpatient care -- and that 1,000 acute care general hospitals are currently planning to establish psychiatric units. He warned that the rapid influx of for-profit providers would increase the competitive pressure on all providers to standardize care and maximize reimbursements. This trend, in turn, will accentuate the growth of a two-track system of mental health care: private and public.

Dr. Schlesinger was followed by Kevin Concannon, Commissioner, Maine Department of Mental Health and Mental Retardation. Maine has avoided an influx of for-profit mental health and substance abuse providers through the use of a strong "certificate-of-need" process. In addition, four major state child-serving agencies -- mental health and retardation, corrections, education, and human services -- jointly coordinate the planning and needs assessment efforts, licensing of these facilities, funding, and oversight of the range of residential treatment centers operating in Maine serving disturbed children and adolescents. Mr. Concannon stated that, as a result, Maine has reduced beds in residential treatment centers and expanded home-based services which prevent out-of-home placements for children and adolescents.

The final witness appearing before the Committee was Mr. Albert Richard, Jr., Chief Juvenile Probation Officer, Dallas County, Texas. Mr. Richard testified that he has been heavily lobbied by recruiters from for-profit substance abuse treatment facilities in the Dallas area to refer youngsters on probation. Frustrated parents also frequently request referral of their troubled teenage children to these facilities. Growth of for-profit providers has been especially rapid in the wake of recent state legislation which mandates insurance coverage of alcohol treatment and abolishes the requirement for certificates-of-need for alcohol treatment facilities. In response, Mr. Richard testified that a grassroots effort has begun in the Dallas community to more closely assess the service needs of troubled youth and their families.

EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS:
A FACT SHEET

ADMISSIONS OF ADOLESCENTS TO INPATIENT PSYCHIATRIC FACILITIES ARE INCREASING

* Between 1980 and 1984, admissions of adolescents to private psychiatric hospitals increased an estimated 450% -- rising from 10,764 to 48,375. (NAPPH, 1985)

* Nationwide, the number of children and youth in facilities caring for dependent and neglected children declined 59% between 1966 and 1981 -- from 60,459 to 24,712 -- while the number of children and youth in facilities caring for mentally ill and emotionally disturbed children increased 57% -- from 21,904 to 34,495. (GAO,1985)

* In Minnesota, the rate of psychiatric admissions for juveniles has increased from 91 per 100,000 admissions in 1976 to 184 per 100,000 in 1983. The proportion of juveniles receiving inpatient treatment for chemical dependency increased from 17% in 1978 to 23% in 1982. (Ira Schwartz, Marilyn Jackson-Beeck, Roger Anderson, Crime and Delinquency, July, 1984)

MANY PSYCHIATRIC ADMISSIONS FOR ADOLESCENTS MAY BE UNNECESSARY WHILE THE MAJORITY OF SERIOUSLY ILL CHILDREN GO UNTREATED

* Of the estimated 3 million seriously disturbed children and youth in this country, two-thirds are not getting the services they need. Many others receive inappropriate care -- studies suggest at least 40% of the hospital placements of children and youth are unnecessary, or the children remain much too long. (Children's Defense Fund, 1982; L. B. Silver, paper presented at the American Psychiatric Association/Society of Professors of Child Psychiatry Conference, 1983)

* In 1982, Blue Shield of Minnesota found that 25% of juveniles' inpatient days in Minnesota psychiatric and chemical dependency facilities were medically unnecessary. (Schwartz, Jackson-Beeck, Anderson, 1984)

* The top five diagnoses for juveniles admitted to Minnesota psychiatric facilities in 1982 were very broad and not clearly indicative of serious mental illness:
1) disturbance of emotion specific to childhood and adolescence; 2) neurotic disorder; 3) disturbance of conduct; 4) unspecified adjustment reaction; 5) depression. (Schwartz, Jackson-Beeck, Anderson, 1984)

* According to a recent GAO survey of three states, of the youth that continue to be placed in juvenile justice facilities, the majority are non-white, while over 70% of children and youth placed in health facilities are white. (GAO, 1985)

ONCE LARGELY PUBLIC, MENTAL HEALTH CARE IS INCREASINGLY A PRIVATE SERVICE

Services for Children and Adolescents

* In 1966, 7.6% of the 145 psychiatric facilities for children and youth in the U.S. were operated for profit; by 1981, 17.1% of 369 facilities were operated for profit -- a 125% increase. (OJJDP, 1983)

Services for the General Population

* In the mid-1950's, 97% of psychiatric beds were in specialized public hospitals; by 1982, 76.5% of beds were under public auspices -- 16.4% were in private non-profit general medical hospitals, and 7.1% were in for-profit facilities. (Mark Schlesinger and Robert Dorwart, New England Journal of Medicine, October 11, 1984)

* While representing only 7.1% of the total, for-profit psychiatric beds increased 150% between 1969 and 1982. By 1982, 85% of all for-profit psychiatric facilities were controlled by multifacility corporations -- nearly two-thirds by the five largest chains. (Schlesinger and Dorwart, 1984)

* A 1973 NIMH survey of halfway houses and community residences for the mentally ill revealed that 10% of responding facilities were operated for profit; by 1977, 50% of all such facilities were operated by for-profit multifacility chains. (Schlesinger and Dorwart, 1984)

FACTORS THAT MAY BE FUELING INPATIENT PSYCHIATRIC ADMISSIONS OF ADOLESCENTS

States are deinstitutionalizing troubled youth in juvenile justice facilities

* In 1979, 199,341 non-delinquent youth were held in secure facilities; by 1981, 22,833 non-delinquent youth were in such facilities. (OJJDP, 1984)

* Nationwide, the number of children and youth in residential care decreased between 1966 and 1981 -- from 155,905 to 131,419.

Community-based alternatives are not keeping pace with the needs of troubled youth

* In 1981, the Community Mental Health Centers Act was repealed. Funding for community mental health centers was folded into the Alcohol Drug Abuse and Mental Health block grant and has been reduced by more than one-third -- from $306 million in FY 1981 to $227 million in FY 1984. (NIMH, 1985)

* While many states have instituted successful programs to prevent institutionalization of troubled youth, development of necessary services has been hampered by state budgetary constraints and reductions in federal support. Long-range

58-957 O - 86 - 2

planning has also been severely hampered by uncertainty over the future of the Juvenile Justice Delinquency and Prevention Act. (Testimony, State Juvenile Justice Advisory Groups, House Subcommittee on Human Resources, March 7, 1984)

Many states currently mandate mental health coverage; inpatient care more extensively covered than outpatient care

* Currently, 13 states have passed laws mandating insurance coverage for psychiatric care (APA, 1985), 21 states mandate coverage for treatment of alcoholism, and 11 states mandate coverage for treatment of drug addiction (NASADAD, 1985).

* On June 3, 1985, in a unanimous decision, the U.S. Supreme Court in Metropolitan Life Insurance Company v. Commonwealth of Massachusetts upheld a state's right to mandate coverage of specific conditions and illnesses by private insurers. It is expected many more states will enact laws mandating insurance coverage of psychiatric and chemical dependency treatment. (National Mental Health Association, 1985)

* 58% of employees in medium- and large-size establishments have insurance policies which provide the same coverage for inpatient care for mental illness as they do for other illness, but only 10% of employees receive comparable benefits for outpatient mental health care. 54% have outpatient care subject to a 50% copayment, and 62% have separate dollar limits, often $1,000. (APA, 1984)

GAO -- General Accounting Office
NAPPH -- National Association of Private Psychiatric Hospitals
OJJDP -- Office of Juvenile Justice and Delinquency Prevention
NIMH -- National Institute of Mental Health
APA -- American Psychiatric Association
NASADAD -- National Association of State Alcohol and Drug Abuse Directors

SUMMARY OF FULL COMMITTEE HEARING ON "LEARNING FROM THE PRIVATE SECTOR: A DIALOGUE WITH FOUNDATION EXECUTIVES" WASHINGTON, D.C., JUNE 27, 1985

On June 27, 1985, the Select Committee on Children, Youth, and Families held a hearing entitled: "Learning From The Private Sector: A Dialogue With Foundation Executives." The Committee was seeking from key foundation executives answers to the following questions:

1. Have recent changes in family and workplace composition, and in the economic circumstances of families, affected the foundation's pattern of requests, or giving? If so, how have they changed?

2. Based on the foundation's involvement with child and family issues/programs, which approaches hold the greatest promise of success? Which of these approaches are ready to be "scaled up" to serve more children or families?

3. Since public support for children and family services has been reduced, has the foundation been asked to fill in the gaps? What has been the foundation's ability to provide that support? Can the foundation provide this additional support and pursue a "venture capital" function as well?

4. Can the foundation identify examples of positive public-private collaboration in responding to the needs of children and families? Are these growing in number? Do current public policies encourage such partnerships?

5. Based on the foundation's experience, what advice would you offer policymakers concerned with enhancing the well-being of children and families in the coming decade?

The first panel began with the testimony of David A. Hamburg, M.D., President of the Carnegie Corporation of New York. Dr. Hamburg said that although his foundation is an important player in the field of education, for example, foundations cannot fill the gaps created by diminished federal spending on children and youth services. He also said that foundations have flexibility that policymakers do not have, to draw expertise from around the world, to take risks, and to look at the "big picture" of social conditions.

Dr. Hamburg added that programs whose efficacy has been demonstrated in study projects and nearly twenty years of operation, like Head Start and child vaccination programs, in which the Carnegie Corporation has been deeply involved, should now be scaled up by policymakers. Teen pregnancy, the central youth policy issue of the future, must be addressed.

Kirke Wilson, Executive Director of the Rosenberg Foundation of San Francisco, the next witness, began by saying that, not only is the foundation sector unable to fill fiscal gaps, but that it is inappropriate for foundations to try--or for policymakers to direct them to try--to fill these gaps. Wilson said that such gap-filling is a reversal of traditional roles, which have foundations generating ideas and government funding the best of them. He said that the better use of limited foundation resources is to study newer policy problems where there is not yet a consensus on the best approaches, such as the licensing of day care centers, which is a current project of the Rosenberg Foundation.

Wilson directed the attention of the Committee to two central family issues: the changing composition of the family and the changing composition of the population, which, he believes, is at great risk of being further divided along lines of race, class, and age. In California, he said, the great influx of immigrants points to a new role for schools and for local service agencies. It is important for people in the public and private sectors to begin planning since these institutions cannot adapt to the new populations of their own accord.

The next witness was Leonard W. Smith, President of the Skillman Foundation of Detroit. Mr. Smith said the Skillman Foundation usually applies its resources to small, private community organizations, pilot programs and demonstration projects, and community-based public youth assistance programs. He has seen an increase in the number of requests for latch-key and day care programs and believes that preventive programs offer the greatest promise of success. He said that foundations cannot fill funding gaps and it is not their task to do so.

Peter W. Forsythe, Vice President of the Edna McConnell Clark Foundation of New York and the director of its Program For Children, led the second panel. Mr. Forsythe characterized the Program For Children's goal as family preservation -- preventing unnecessary juvenile institutionalization and foster care placement. It funds projects designed to prevent the removal of children from their families by changing some of the procedures of child protective services (i.e., bureaus of child welfare and juvenile and family courts) and by training personnel to assure that these services are provided.

Forsythe cited Public Law 96-272 as one example of legislation which grew out of the work of the Clark Foundation and the Program For Children. He suggested that such public-private partnership can produce significant results but that, as in the case of the "reasonable efforts" provision of P.L. 96-272, it is as important for both partners to follow through with program implementation in the areas they have already worked on.

He noted that the pattern of requests the Foundation receives has not changed, demographic shifts have increased the number of families on the brink of dismemberment, without increasing the pool of resources available to the Clark Foundation or other foundations concerned with children.

As a guideline for policymakers concerned with the most serious children's issues of today, Forsythe suggested a focus on teen pregnancy.

The next witness was Ruby P. Hearn, Ph.D., Vice President of the Robert Wood Johnson Foundation of Princeton, New Jersey. Dr. Hearn identified infant mortality as one of the Foundation's major concerns, explaining that infant mortality accounts for over 70% of all deaths to children under 15 years of age. The Foundation, she said, has attacked this problem through its Regional Perinatal Care Program and Rural Infant Care Program, both of which were conducted with public-sector partners and both of which brought dramatic reductions in rates of infant mortality.

Dr. Hearn said that it is particularly hard for foundations to fill public funding gaps in health care since only 2% of health

costs are paid for by private philanthropy, and only 1/10 of that percentage is paid for by foundations.

The final witness was William L. Bondurant, Executive Director of the Mary Reynolds Babcock Foundation of Winston-Salem, North Carolina. He reported that grant requests to the Foundation doubled in the year after federal budget cuts were enacted. The Foundation changed its pattern of giving in response to a perceived need for more community-based, small-scale service programs; whereas most of its grants used to go to colleges and universities, most now go to smaller, less traditional institutions.

Mr. Bondurant said that the keys to national programming for children by both foundations and the public sector are to examine problems that local agencies will not or can not examine, to focus on replication of successful program models rather than on "start-from-scratch" demonstration projects, and to work with local communities on tailoring programs to their needs and desires.

Bondurant also stressed that both public and private dollars have greater impact if they focus on total family needs rather than on the needs of children alone. This belief has led his Foundation to support programs which help women, particularly those heading households, to secure and keep well-paying jobs, in addition to supporting advocacy groups, community youth service agencies, and a program for the education of gifted minority youth.

FOUNDATION GRANTS FOR CHILDREN AND YOUTH
A FACT SHEET

FOUNDATION GIVING IS INCREASING

Independent Foundations

* Between 1980 and 1984, giving by private, independent foundations increased 55%, from $2.81 billion to $4.36 billion. Independent foundations made up 5.8% of total private giving in 1984. (American Association of Fund-Raising Counsel, Inc. [AAFRC], Annual Report, 1985)

Corporate Foundations

* Between 1980 and 1984, giving by corporate foundations increased 32.6% -- from $2.6 billion to $3.45 billion. Corporate foundations made up 4.7% of total private giving in 1984. (AAFRC, 1985.)

PRIVATE INDIVIDUAL GIVING, WHICH REPRESENTS THE BULK OF NON-GOVERNMENTAL FUNDING, IS ALSO GROWING

* Giving by private individuals, which made up 89.5% of all private giving in 1984, increased 51.2% between 1980 and 1984 -- from $40.71 billion to $61.55 billion. (AAFRC, 1985)

DESPITE INCREASES, PRIVATE GIVING HAS NOT OFFSET FEDERAL BUDGET CUTS

Total Spending

* Federal support for all non-profit organizations (social service organizations, community development organizations, etc.), exclusive of the share that goes to hospitals and other health providers under Medicare and Medicaid, decreased between FY 1982 and FY 1985 by a total of $17 billion below what it would have been if FY 1980 spending levels had been maintained. (Salamon/Abramson, Foundation News, 1985)

* Total private giving offset about 5% of the federal cuts and 17% of the estimated direct revenue losses sustained by these nonprofit organizations between 1980 and 1983. (Salamon/Abramson, Foundation News, 1985)

Spending for Child-Serving Agencies

* Those non-profit agencies, more than half of whose clients are children, receive the bulk of their revenues from government sources (42.4% in 1982). Overall, between 1980 and 1982, these agencies lost 3.4% in inflation-adjusted federal dollars at a time when demand for services was sharply increasing -- recreation services lost 11.2%, education and research lost 7.9%, and day care services lost 7.5%. During this period, 43% of child-serving non-profits reported a loss in government support. (The Urban Institute, 1985)

* To help make up for the lost funds, foundations and corporations have increased grant expenditures to

child-serving agencies. Between 1980 and 1982, 38% of child-serving agencies experienced increases -- the typical agency received a 6.3% increase in corporate support and a 9.6% increase in foundation support. However, in FY 1982, corporate funding still only represented, on average, 3.4% of total revenues for child-serving agencies, and foundation funding represented 3.5% of their total revenues. To help meet their funding shortages, between 1981 and 1982, one-third of child-serving agencies increased or instituted service fees to clients, 16% of agencies eliminated specific service programs, and 13% reduced the number of clients served. (The Urban Institute, 1985)

FOUNDATION SUPPORT TO PROGRAMS FOR CHILDREN AND YOUTH IS ALSO GROWING

* Based on a sample of over 400 independent and corporate foundations, representing 45% of all grant expenditures, foundation giving for programs benefiting children and youth increased from $86.5 million in 1980 (7.3% of all grants) to $177.5 million in 1984 (10.8% of all grants). (The Foundation Center, 1985) 1/

* Foundation giving for elementary and secondary schools and education programs increased from $36.3 million in 1980 (3% of all grants) to a peak of $56.4 million in 1983 (3.1% of all grants), but then declined to $43.9 million in 1984 (2.7% of all grants). (The Foundation Center, 1984) 2/

* During 1982 and early 1983, the top six categories of children and youth programs receiving more than $10 million in foundation grants were: general welfare ($37.7 million), medical care ($29 million), recreation ($21 million), business or employment ($17.9 million), public health ($12.5 million), non-school elementary or secondary education programs ($12 million). (The Foundation Center, 1984).

* During 1982 and early 1983, nearly 48% of foundation giving for programs benefiting children and youth went to agencies providing direct services, such as adoption and foster care services; the remaining 52% of grants were distributed among other kinds of agencies, such as hospitals or medical care facilities (8.2% of the total), association or professional societies (6.2% of the total), and graduate schools (5.6% of the total). (The Foundation Center, 1984)

1/ In contrast, the Supplemental Feeding Program for Women, Infants and Children (WIC) is funded at $1.05 billion for FY 1985, but serves approximately one-third of those eligible.

2/ In contrast, the largest federal program for elementary and secondary students, Chapter I (Compensatory Education) of the Education Consolidation and Improvement Act, is funded at $3.7 billion for FY 1985, but even at its peak has served fewer than 50% of the eligible students.

SUMMARY OF FULL COMMITTEE HEARINGS ON "CHILD CARE: THE EMERGING INSURANCE CRISIS, PARTS I AND II" WASHINGTON, D.C., JULY 18 AND 30, 1985

The Select Committee on Children, Youth, and Families convened hearings to investigate the reduced availability of liability insurance for providers of child care services.

Congressman James Florio, Chairman of the House Subcommittee on Commerce, Transportation and Tourism, Committee on Energy and Commerce, which has jurisdiction over insurance, expressed his concern regarding the insurance industry's curtailing of liability insurance. "The insurance industry seems to want the best of many worlds: the industry wants to withhold coverage from all but what it determines to be the smallest and most profitable risks."

Child care providers testified about their own recent experiences with insurance coverage. Alyce Chessnoe, President of the Northern Virginia Family Day Care Association, and Karen Solon, a family day care provider in northern Virginia, described their crises. Chessnoe had her liability coverage cancelled mid-term by Mission Insurance, effective September 1, 1985, after sequential and substantial rate increases in the preceding 6 months. Solon's policy was simply not renewed when her contract expired on July 1. If a new insurer is not found, she will discontinue providing child care services.

Providers in the 170-member Northern Virginia Family Day Care Association whose coverage was due to expire had policies cancelled without notice; all others were given mid-term cancellation notices effective within 60 days, even though no one had ever filed a claim. As Chessnoe told the Committee: "In the meantime, our insurance committee has searched out every possibility that they heard of. Still nothing. NOTHING! No insurance at any rate...No insurance with exceptions added. NOTHING!"

The Baltimore YWCA never filed a liability claim, but their original policy was cancelled last spring. Jean Weaver, Day Care Coordinator at the YWCA in Baltimore, Maryland, testified, "The increase in insurance premiums, or, failure to find insurance could push our Board to the unwelcome conclusion that we should limit our day care program to the affluent, or, that we should cease to provide the service. We hate to think of the disruption that such solutions would cause to families who are dependent on us for care." The YWCA runs 11 child care centers serving over 800 children (50% of the children cared for are subsidized by the state), numerous youth programs, and 3 shelters for the homeless.

The original insurer, which had underwritten the group policy for the YWCAs nationwide, cancelled the group coverage, and was accepting YWCAs on an individual basis only if day care, shelter, or team sports programs were discontinued.

Sandra Gellert, President of the National Association for Family Day Care, Clifton Heights, Pennsylvania, stressed that "the crisis in the liability insurance industry for family day care providers is of critical proportion. During recent weeks, one insurance company after another, from Maine to California and Washington to Florida, has cancelled liability policies for family day care homes....Many family day care providers will go out of business." Given the estimates that two-thirds of all children in day care and 85% of infants in day care are in family day care home

settings, Gellert suggested that many families would have difficulties meeting their child care needs.

In addition to the availability problem, providers cannot afford the high premium rates being offered by some companies. The $759 rate they have been quoted is one month's income for a family day care provider. For the most part, families dependent on this service will not be able to absorb the increased cost either.

In several states where liability coverage is required before a child care program can be licensed, Gellert told the Committee, "the continuation and growth of home based-child care is at a standstill."

Deborah Phillips, Director of the Child Care Information Service of the National Association for the Education of Young Children (NAEYC), Washington, D.C., which represents 47,000 individuals who work in all facets of early education, emphasized, "the loss of insurance and the prohibitive rate increases we are seeing bear no relation to the professionalism, quality, or claims history of the program affected." The only national study on the issue suggests that over two-thirds of the child care programs surveyed are facing serious insurance problems. Many child care programs, especially those serving Title XX and other low-income children, are unwilling or unable to pass increased insurance costs onto the families they serve.

NAEYC's policy, which covered many of its member child care centers, was cancelled earlier this year. A second underwriter almost withdrew before an exclusion for child abuse claims and stringent quality standards were negotiated. Those standards are higher than any current state standards that child care programs must meet to be licensed.

The problem is exacerbated in over half the states where liability insurance is required for child care centers to be licensed. Eleven states require it for licensed family day care centers. Programs without insurance in these states are technically ineligible for federal Title XX or Child Care Food Program funding, which requires programs to meet state standards.

James J. Chastain, Professor of Insurance and Director of the Center for Insurance Education at Howard University in Washington, D.C., presented an overview of insurance. He described the underwriting cycle: "At the top of the cycle prices are high, underwriting is moderate producing good profit. This encourages new capital into the business, looser underwriting, and reduced rates. Profits decline....The turning point in the cycle occurs only when company executives become alarmed by financial failure of some other companies, where there is unrest among the owners of the company or when the reinsurance market tightens."

General Liability insurance, which includes child care liability, experienced losses in 1983 that were worse than the average of all property/casualty insurance. Insurers are also concerned about the "long tail of exposure" that occurs when insuring children, because insurers may be responsible for a loss litigated many years after the policy is purchased.

Chastain described the present child care insurance market situation more as a problem than as a crisis, since an improved phase of the underwriting cycle will emerge in two to three years. "However, it is still true that 'we are all dead in the long run' and improvement

likely to occur in two or three years does not satisfy the child care business owner with an immediate problem of availability or affordability of liability insurance."

As solutions, Chastain suggested better communication and the legalization of group insurance and risk retention groups.

The Committee also heard from insurance brokers, who function as intermediaries between child care providers and the insurance industry.

Joseph S. Silverman, Executive Vice President of BMF Marketing, Sherman Oaks, California, testified that BMF was the broker which provided a specialty liability insurance program for family day care providers through the Mission Insurance Company. On July 1, 1985, Mission processed mid-term cancellation notices to its family day care liability policy holders nationwide.

BMF has contacted over 50 companies and found one, licensed only in California, willing to offer insurance for family day care.

In his experience, there has been little claims activity for child care that should discourage companies from offering the insurance, provided that they can maintain adequate premium levels. The insurance industry has raised the following reasons for concern regarding child care liability coverage: adverse publicity about child sexual abuse; high legal expenses in cases having to do with minors; the large number of new family day care providers (70% are unlicensed and subject to relatively little regulation); and the tort system, which seems to be biased against the industry.

Silverman also raised the issue of cancellation of homeowner policies for people caring for children in their homes. Legislation was recently passed in Washington state prohibiting the cancellation or refusal to write homeowner's insurance because of day care activities.

Georgia Yocum, the owner of Loma Rica brokerage firm in Grass Valley, California, testifed that a solution was imminent and that the lines of communication should be kept open between all concerned parties.

Yocum told the Committee that 75% of insurance companies that write 95% of all liability insurance lost reinsurance because they mismanaged the business by discounting premiums too often. She concurred with Silverman that the withdrawal from writing child care liability insurance was completely unrelated to any risk associated with child care, and that insurers should be educated that child care is an underwritable and profitable risk.

In order to hear from the insurance industry, and regulators of the insurance industry, the Select Committee convened a second day of hearings.

Edward J. Muhl, Insurance Commissioner from Maryland, spoke on behalf of the National Association of Insurance Commissioners (NAIC). Muhl informed the Committee that he was prohibiting mid-term cancellations or rate hikes in Maryland. He also proposed continued communication with insurance providers, and exclusions for child abuse. According to Muhl, Joint Underwriting Associations, where insurance companies are required by the state to provide coverage for certain lines if they want to continue to sell insurance in that state, are short-term solutions that present problems in the long run.

Muhl said that the insurance industry is facing an unusually severe low end of the historical cycle. He also pointed out that reinsurance industries, in the U.S. and internationally, have for the first time *sustained a continuous loss. The financial solvency of many U.S.* companies is in question and is being monitored by the NAIC.

Cashflow underwriting, or the practice of heavily discounting premiums so they can be quickly invested for high yields during periods of high interest rates, is another factor adding to the industry's current inability to write insurance.

Child care facilities are caught up in this availability crunch because of hysteria about abuse in child care facilities, not necessarily because of claims experience.

The Insurance Services Office is a non-profit corporation that makes available rating, statistical, actuarial, and related services to any United States property/casualty insurer. Mavis Walters, Senior Vice President, of the Insurance Services Offices (ISO), Washington, D.C., presented the most recent data available for those companies reporting liability premium and loss data for day nurseries to ISO for ratemaking purposes: In 1980, there was a $.70 loss for every dollar of earned premium; In 1983, over $1.33 was lost for each dollar of premium earned. (Investment income for day nurseries was not reported.)

Walters also provided her perspective on the history that led to current liability insurance problems. Since 1980, losses and expenses have exceeded premiums primarily because prices failed to keep pace with loss costs. There has been an average annual rate of loss of $3 billion. In 1984, underwriting losses jumped $8 billion. Investment income grew continuously, but not enough to cover losses. According to Walters, the contributing factors were: excessive costs of the civil justice system; a decline in policyholder surplus (difference between insurer's assets and liabilities); a capacity shortage of $62 billion over the next three years (91% in commercial lines); and the inability of primary insurers to obtain adequate reinsurance.

Frank Neuhauser, an actuary from AIG Risk Management, Inc., New York, researched the current problem of insurance coverage for child care providers, and found that no awards for child abuse claims have been made. He did stress, however, that the potential for abuse remains, and insurance companies are fearful of large claims in the future.

Loss data that are available do not indicate that child care providers, as a group, are any better or worse than average. Child care associations have been able to command reduced premiums and less selective underwriting, and have therefore been an unprofitable line.

The insurance industry has reached the point where demand has exceeded their ability to provide coverage. New underwriting criteria will include stringent standards that child care programs will have to meet before they will be eligible for insurance.

According to Neuhauser, permanent solutions will require significant changes in the tort system. Other short term solutions might include exclusions for physical and sexual abuse; stricter licensing and enforcement standards; lower limits of liability; no-fault benefits as in workers' compensation; and, claims-made policies, rather than occurrences policies.

James Kimble, Senior Counsel at the American Insurance Association, Washington, D.C., a national trade organization of casualty insurers, testified that although ISO data suggest losses comparable to aggregate general liability, they do not suggest that insurers should abandon the market.

He reminded the Committee that insurance availability and affordability are not confined to the day care industry. In 1984, the insurance industry lost $4 billion in surplus.

Recent publicity about abuse in child care, in the insurance industry's judgment, could result in increases in the number and severity of claims. Even if abuse is excluded from the policy, plaintiff attorneys could finesse the exclusions by claiming negligence in hiring practices.

Kimble proposed that solutions should come voluntarily from the private sector.

The Committee also heard from the Honorable Peter Nystrom, state representative from Norwich, Connecticut, who shared his concern about the issue of insurance coverage for child care. He outlined proposed recommendations that are being considered in Connecticut to resolve the problem.

Robert Hunter, President of the National Insurance Consumer Organization, Alexandria, Virginia, responded to the insurance industry's claims about reported losses. He informed the committee that based on Best's financial indicators, insurance companies are still rated very high by Wall Street because the usual recovery is expected over the next 18 months.

He suggested that current problems in the insurance industry are self-inflicted. Previous lows in the cycle led to state tort law changes which curtailed victims rights, or to panic pricing. At the top of the cycle, insurers cut premiums to increase cash flow for investment.

Hunter analyzed the actuarial data on day nurseries from the Insurance Services Office, which does not indicate how many day care facilities were included. "Even looking at the worst year, 1983, the data don't look like a crisis." Between 1980-83, there were 1,121 claims filed nationwide. This represents a loss of about $500,000, that would only require a 50% rate change for 1986. It is likely that less than $1 million of the ISO-reported $5 million in claims has actually been paid out.

In any case, the losses attributed to child care are significantly less than other property/casualty categories and account for very small percentages of premiums written, and a small percentage of losses.

Hunter's solutions included modeling legislation after the Urban Property Protection and Reinsurance Act of 1968. The federal government would agree to provide reinsurance to primary insurers in return for a reinsurance premium and a commitment to participate in a pool to make insurance available to those having difficulty obtaining insurance. Standards for insurability would have to be set.

Thomas L. Birch, Legislative Counsel for the National Child Abuse Coalition, Washington, D.C., assured the committee that despite news stories that report alarming cases of sexual maltreatment in child care settings, there is no data to support the notion that children in day care are at high risk of abuse and neglect. While there were over 1 million documented cases of child abuse and neglect in 1983, child sexual maltreatment accounted for only 8.5% of all documented abuse cases.

In addition, in 97.1% of sexual maltreatment cases, a parent or relative is the perpetrator. The remaining 3% of the perpetrators include babysitters, teachers, neighbors, strangers, parents' friends, and the staff of state and private insitutions. The American Humane Association estimates that between 1% and 1.5% of the reported perpetrators of child sexual abuse are day care employees.

Contrary to the impression created by the adverse publicity, it is well known that child care relieves family stress and isolation and is an important abuse prevention tool. Birch stressed the importance of training child care staff, parents and the public in recognizing and preventing abuse.

SUMMARY OF FULL COMMITTEE HEARING ON "MELTING POT: FACT OR FICTION?"
WASHINGTON, D.C., SEPTEMBER 26, 1985

The Select Committee on Children, Youth, and Families held a hearing in conjunction with the Congressional Black Caucus on September 26, 1985, in Washington, DC. The hearing focused on the ability of minority and immigrant families to "make it" in today's society. Barriers to progress were discussed, as well as successes.

Leon Bouvier, Ph.D., Vice President of the Population Reference Bureau in Washington, D.C., discussed current demographic shifts occurring in the U.S. and, using immigration and fertility trends, projected future changes in the population. Hispanics and Asians are currently the primary immigrant groups. Their populations will grow more rapidly than non-Hispanic whites, and by the year 2030, roughly one out of three people living in the U.S. will be black, Hispanic or Asian. Dr. Bouvier concluded with a discussion of the impact of these changes on education, marriage, housing, and the labor force.

The second witness, Harriette McAdoo, Ph.D, Professor of Social Work at Howard University in Washington, D.C., provided an overview of the experiences of black Americans. Historically, three forces have disrupted the structure of black families and influenced patterns of upward mobility: enslavement, northern industrialization and recent increases in poverty. These factors have led to an increase in unemployed black males who are unable to assume the traditional role of father when a child is born, hence the significant increase in black families headed by single females. Roughly 44 percent of black male teenagers are unemployed. Currently, over 46 percent of all black children live in poverty, and black children continue to suffer poorer health and fewer educational and job opportunities.

Dr. McAdoo was followed by Ray Hammond, M.D., Executive Director of the Efficacy Committee, Inc. in Somerville, MA. Dr. Hammond said that the destructive effects of slavery and later discrimination are responsible for many of the problems of black Americans, however, problems of intellectual performance and development are also significant barriers to success. These problems are not due to a lack of ability or intelligence. Rather, they result from the avoidance by many blacks to engage in intellectual competition because of an internalized, "centuries old" image of black intellectual inferiority.

Dr. Hammond called for the black middle class to spearhead a national movement to foster higher expectations among black children, and for government to continue to protect educational and job opportunities. Dr. Hammond has developed a project in the Detroit Public School System which trains ninth grade Chapter 1 students in the psychology of performance as a means of enhancing their academic performance. In addition, a corps of volunteers from the community serves as role models and tutors for the students.

David Swinton, Ph.D., Director of the Southern Center for Studies in Public Policy at Clark College in Atlanta, GA, described in more detail current economic conditions for blacks. Real income for blacks has declined over the last 10 years, and the percentage of blacks in poverty has significantly increased. Poverty rates for blacks in the Midwest region more than doubled since 1970, and increased by over two-thirds in the Northeast. Swinton believes that government policies to improve the economic condition of blacks have been ineffective because they focused exclusively on job training and

eliminating discrimination, and not on the creation of more high paying jobs. Without more employment opportunities, future economic prospects for blacks look bleak.

The second panel began with a presentation by Saskia Sassen-Koob, Ph.D., Associate Professor of Urban Economics at the School of Architecture and Planning at Columbia University. She spoke of the large increase in immigrants and the fact that, contrary to popular belief, over half of all immigrants admitted to this country are women. The economic, social and cultural impact of immigrants is greater than their actual share in the overall population because of their geographic concentration in a small number of areas. The occupational concentration of women immigrants is higher than that of immigrant men and native men and women, as nearly half of all immigrant women are concentrated in two occupations: operatives and services.

Mr. Vu-Van-Ngo, a father and Vietnamese refugee, continued this panel by relating his experience in coming to this country 10 years ago with his wife and seven children. Although Mr. Vu was a research specialist in Vietnam, the only work he and his wife could find in the U.S. was low-skilled labor. They had difficulty at first with transportation and language. After many years of working 2 and 3 jobs at the same time, Mr. Vu and his family now own a restaurant in Arlington, VA. He told Committee members that all his children work with him and his wife, and that he has not taken a vacation since he arrived. Kim Cook, Executive Director of the Mutual Assistance Association Consortium of Northern Virginia, translated for Mr. Vu.

Mr. Vu's daughter, Vu-Thu-Trang, also spoke of the difficulties she faced as a young girl in a new country. At 14, Trang was put in charge of caring for her siblings and preparing dinner because her parents worked. Her first two years here were very traumatic because she did not speak English, and her school did not provide any bilingual or English As A Second Language classes, which made her shy and fearful. She also misses her grandparents and other relatives who remained in Vietnam.

The final witness was Suzan Shown Harjo, Executive Director of the National Congress of American Indians, Washington, D.C., who spoke of the experience of Native American families. Native American people have the highest birth rate, and the highest mortality rate in this country. From 1969 to 1974, 25% to 35% of Indian children were placed in foster care or institutions, or adopted. While the Indian Child Welfare Act of 1978 was designed to address this problem, Indian children are still more likely to be separated from their families than non-Indian children. Indian unemployment stands at roughly 65%, and runs as high as 90% in some tribes. Family stability has been made more tenuous by forced relocations and loss of land.

MELTING POT: FACT OR FICTION?
A FACT SHEET

POPULATION AND IMMIGRATION TRENDS

-- In 1980, the total U.S. population was 226.5 million. Of that, 188.4 million were white, 26.5 million were black, 1.4 million were American Indian, Eskimo, or Aleut, and 3.5 million were Asian and Pacific Islander. Persons of Spanish origin, who may be of any race, numbered 14.6 million. (Bureau of the Census, 1985)

-- By 2030, given current trends in fertility and immigration, the Hispanic population will more than double, from 14.5 million to 37 million, nearly equaling the black population. The Asian population will more than quadruple, from 3.5 million to 17 million. Although their numbers will have increased by 15 million in 2030, the non-Hispanic white population will have declined to 69 percent of the total population. (Bouvier, Population Reference Bureau, 1985)

-- Since 1930, more than half of all immigrants to the United States have been female, and two-thirds have been women and children. (Department of Labor, 1985)

FAMILY INCOME CHARACTERISTICS

Children

-- In 1984, the poverty rate for black children was 46.2 percent; for Hispanic children, 38.7 percent. One out of three Native American children under 18 was poor in 1980. (Bureau of the Census, 1980 and 1985)

-- Black children in two-parent families are twice as likely as white children in two-parent families to be living in poverty. (Children's Defense Fund, 1985)

-- Two-thirds of all black children in female-headed families are poor, 71 percent of all such Hispanic children live in poverty, the highest rate of poverty for any group of children. (Bureau of the Census, 1985)

Families

-- From 1974 to 1984, real median family income for black families dropped 8.5 percent; for families of Spanish origin, 6.3 percent; for whites families, 2 percent. In 1974, white median family income was 67 percent higher than for black families; by 1984, nearly 80 percent higher. (Bureau of the Census, 1985)

-- In 1982, median income for families of Cuban origin was $18,009; for families of Puerto Rican origin, $11,256. (Bureau of the Census, 1982)

-- In single-parent households, two-thirds of white parents are employed; less than 50 percent of black, Hispanic or Native American parents have jobs. (Bureau of Labor Statistics, 1985)

-- Seventy-three percent of Native American married-couple households had at least one adult working in 1980. (Bureau of the Census, 1980)

-- After an average of 32 months residence in the U.S., 16 percent of 1,400 Southeast Asian refugee households surveyed had incomes at or above the poverty level. Sixty-nine percent of the refugees held low-status jobs; their economic improvement resulted almost exclusively from increasing the number of household members in the workforce, not from improvements in individual jobs. (Institute for Social Research, University of Michigan, 1985)

TRENDS IN EDUCATION AND EMPLOYMENT

Academic skills and language

-- Despite significant improvements in minority reading skills in the past 14 years, the gap between black and white performance remains great; only 16 percent of black children were adept at reading at age 17, compared with 45 percent of white children of the same age. (National Assessment of Educational Progress, 1985).

-- Eighty percent of Hispanic and 85 percent of black 17-year-old high school students lack the language skills needed to handle college-level work. Fifty-five percent of white 17-year-olds lack these skills. (National Assessment of Educational Progress, 1985)

-- Approximately 10 percent of Hispanic children aged 8-13, and about 25 percent of those aged 14-20, are enrolled below grade level. (National Council of La Raza, 1985)

-- In a study of 350 Southeast Asian refugee children, 27 percent scored in the 90th percentile on math achievement -- almost 3 times the national average. Twenty-seven percent also earned a general grade-point average of A or A-. Most of the children came to the U.S. with no knowledge of English. (Institute of Social Research, 1985)

-- In 1982, there were approximately 2.4 million children in the U.S. with limited English proficiency. In 1980, 21 percent of students in San Francisco; 19 percent in Los Angeles; 19 percent in Boston; and 6 percent in New York, had limited skills in English. By 1984, these figures had risen to 29 percent in San Francisco, and 23 percent in Los Angeles. (Fernandez, 1984)

Dropout rates

-- In 1984, more than 1 in 4 Hispanic 18 and 19 year olds were high school dropouts, as were 17 percent of blacks and 15 percent of whites. Some studies estimate a Hispanic dropout rate of 80 percent in New York City, 70 percent in Chicago, and 50 percent in Los Angeles. (Bureau of the Census; Hispanic Policy Development Project, 1984)

-- The national high school dropout rate for Native Americans averages 48 percent. Studies conducted in some urban high schools found dropout rates as high as 85 percent for Native

American and 80 percent for Puerto Rican students. (National Coalition of Advocates for Students, 1985).

College enrollment

-- In 1977, college attendance rates were about the same for blacks and whites; by 1982, whites were about 45 percent more likely than blacks to attend college. (Children's Defense Fund, 1985)

-- Over half of Hispanic and Native American college students, and over 40 percent of black and Asian students, were enrolled in 2-year colleges. (American Council on Education, 1984)

-- Blacks received 6 percent, and Hispanics only 2 percent, of bachelor's degrees awarded in 1980. (American Council on Education, 1984)

-- White children are three times more likely than black children to live in families headed by college graduates. (Children's Defense Fund, 1985)

Youth unemployment

-- In 1984, the official unemployment rate for youth aged 16-19, was 19 percent; for black youth, 43 percent; for white youth, 16 percent; for Hispanic youth, 14 percent. (Department of Labor, 1984)

-- In 1984, the real youth unemployment rate which includes discouraged job seekers, was 31 percent; for black youth, 58 percent; for white youth, 27 percent; and for Hispanic youth, 19 percent. (Roosevelt Centennial Youth Project, 1984)

Concentration of minority students in schools

-- More than one-fourth of Hispanics attended schools with minority enrollments of 90-100 percent. (National Council of La Raza, 1985)

-- Twenty-two out of the 26 largest school systems in the country had enrollments of more than 50 percent minority students. (Fernandez, 1984)

-- A recent longitudinal study shows that black children who attended racially mixed schools were more likely to graduate from high school and complete more years of college. (Center for Social Organization, Johns Hopkins University, 1985)

HEALTH TRENDS

Infant mortality and low birthweight

-- The gap in black/white infant mortality rates (IMR) was wider in 1982 than at any time since 1966. In 1982, the IMR for black infants was 19.6 for each 1,000 live births, compared to 10.1 for whites. (Department of Health and Human Services, 1984)

-- In 1983, the low birthweight rate for infants of all races was 6.8 percent; 5.7 percent for whites, and 12.6 percent for blacks. Black and white low birthweight rates showed the widest gap since 1970. (National Center for Health Statistics, 1985)

Other health indices

-- In 1983, 10 percent of black women and 12.5 percent of Hispanic women received late or no prenatal care. (National Center for Health Statistics, 1985)

-- Black preschool children are six times more likely than white children to have elevated blood lead levels. (National Center for Health Statistics, 1982)

-- Between 47 percent and 61 percent of black preschoolers are not fully immunized against one or more preventable childhood diseases, compared to between 33 percent and 43 percent of white preschoolers. (Children's Defense Fund, 1985)

-- Native American and Hispanic children show the highest prevalence of growth stunting and obesity - 2 to 3 times that found among all children ages 2 to 4 -- suggesting that the quality of diet for these children is inadequate. (Centers for Disease Control, 1982)

SUMMARY OF PREVENTION STRATEGIES AND CRISIS INTERVENTION TASK FORCES HEARING ON "CHILD VICTIMS OF EXPLOITATION" WASHINGTON, D.C., OCTOBER 31, 1985

On October 31, 1985, the Crisis Intervention Task Force of the Select Committee on Children, Youth, and Families held a hearing on the problem of sexual and criminal victimization of young children and teenagers.

The hearing began with testimony from Representative John McCain (R-AZ). Mr. McCain has introduced legislation addressing the sexual exploitation of children. His bill (H.R. 2539) amends Title 18 of the U.S. code to include child exploitation crimes under the Racketeer Influenced and Corrupt Organizations (RICO) provisions, prohibits advertising of child pornography, and stiffens penalities for those who transport minors across state lines for the purpose of sexual exploitation.

The first panel of witnesses began with Kenneth Lanning, Special Agent, Behavioral Science Unit, Training Division, Federal Bureau of Investigation.

Mr. Lanning dispelled the stereotype of a pedophile as a stranger waiting for children on a street corner. Pedophiles, he testified, look like anyone else and usually nonviolently seduce children they befriend. Some become involved with single parents to attain access to their children. Most seek employment which brings them into regular contact with children. Pedophiles frequently photograph their victims, sometimes using the pictures to blackmail the children into silence, or keep the photos as a momento. They also typically collect child pornography and child erotica obtained from books, magazines, videotapes, exchanged photographs, etc.

Mr. Lanning further testified that few child victims of sexual exploitation are abducted. Most are seduced by pedophiles that they know and then return home each day without their parents realizing what is happening.

Committee Members next heard from Victoria Wagner, Executive Director, Seattle Youth and Community Services, Seattle, Washington.

Ms. Wagner described the activities of Orion Center, a comprehensive program to provide a safe alternative to street life and help in the transition of youth from the street to productive lifestyles. Established two years ago with a federal demonstration grant, Orion Center offers short and long term counseling, street outreach services, health care, education and employment services, emergency shelter, and a drop-in center.

Orion Center provided services to 700 youth in its first 15 months of operation, over half of whom were involved in prostitution. Intake data indicate 26% of the youth served had been sexually abused, usually by family members, and 39% had been physically abused. While the Center has had good success, the longer a child is on the street the more difficult a positive transition becomes, and the more services are needed.

Michael Jupp, Executive Director, Defense for Children International -- U.S.A., in Brooklyn, New York, concluded this panel.

Mr. Jupp testified that Defense for Children, International, an initiative of the International Year of the Child, has uncovered in many nations examples of sexual exploitation of children. Mr. Jupp stated there are international links between different kinds of sexual

exploitation and described pornographic photos of American children which appear in European magazines distributed in the U.S. Also, there are advertisements in these magazines for "sex tours" in East Asian nations, where children are kept in bordellos for sexual use by tourists.

Mr. Jupp described a cycle of abuse where exploited children are photographed, and the photos then used to entice other children into sexual acts. Abused over time, many of these children then become prostitutes as teenagers and adults.

Mr. Jupp noted that despite adequate laws, the U.S. has devoted few resources to investigating and prosecuting cases of child sexual exploitation. He stressed the need for more research to determine the extent of the problem, and the need for a commitment to end the abuse.

The second panel began with Thomas Berg, Director of Clinical Services, Chesapeake Institute, Kensington, Maryland.

Mr. Berg testified that the Chesapeake Institute, established three years ago to provide treatment services for both adult and child victims of child sexual abuse and exploitation, as well as juvenile and adult offenders, has become concerned about the numbers of children who are sexually abused. Mr. Berg stated that studies show one pedophile typically abuses 200-400 children in a ten-year period. Boys are as likely to become victims as girls. Since other studies show nearly 80% of convicted pedophiles were molested as children, Mr. Berg warns that some percent of the 200-400 children molested are likely to become perpetrators. If this is even two children, the number of pedophiles grows "exponentially."

Mr. Berg urged development of a national effort to provide sexual abuse prevention education programs in elementary schools, stronger reporting requirements for child sexual victimization cases, and increased efforts to treat the juvenile offender who is most likely to be amenable to treatment.

Committee Members next heard from Bruce Taylor, Vice President and General Counsel, Citizens for Decency Through Law, located in Phoenix, Arizona.

Mr. Taylor, who described his extensive experience in prosecuting adult pornography cases, testified that producers of adult pornography are typically producers of child pornography, so that child pornography is best dealt with by combating adult pornography. Mr. Taylor stressed that society's attitudes have become tolerant of pornography, allowing the worst forms to flourish, including child pornography. He advocated stronger enforcement of existing obscenity statutes, moral sex education for children in schools, and better services, including shelters, for battered women and children and runaway youth.

The final witness appearing before the Committee was Steven Finkelberg, Metropolitan Police Department, Washington, D.C.

Mr. Finkelberg, who is an undercover police officer assigned to Washington, D.C. schools, described how drug dealers and pushers exploit children. He stated that many adult drug traffickers prefer to use young people in the distribution of drugs because juveniles are easy to control by fear and intimidation, receive lenient treatment from the courts, and open up new markets for the distributor that would be closed to an adult, such as schools, teen groups, or parties.

Mr. Finkelberg described several recent drug cases in which juveniles were used as look-outs, runners and holders of drugs, or became victims of staged hold-ups to trap them into becoming distributors.

While many teenagers become involved in drug trafficking to earn money, Mr. Finkelberg noted that with the exception of marijuana, they get their drugs, whether for use or reseale, from an adult.

To effectively address the problem, Mr. Finkelberg recommended instituting drug awareness programs in the first grade, educating parents through the PTA about the signs and effects of drug abuse, and curtailment of media and music industry dramatization of drug use.

CHILD VICTIMS OF EXPLOITATION
A FACT SHEET

CHILDREN MOST VICTIMIZED BY CRIME

* Children aged 12-15 have the highest victimization rate for crimes of theft for any age group (125.8 per 1,000); children aged 16-19 have the highest victimization rate in crimes of violence for any age group (64.5 per 1,000) and young people age 12-24 have the highest victimization rate for both crimes of violence and crimes of theft. The over-65 population, by contrast, has a victimization rate of violent crime of 5.5 per 1,000 and of theft, 22.9 per 1,000. (U.S. Dept. of Justice, Criminal Victimization in the United States, 1983)

* According to the National Center for Educational statistics, 11%, or 2.4 million, of all American secondary school children have something worth more than $1 stolen from them during any given month. An estimated 1.3%, or 282,000 secondary students report they have been attacked in school during a typical one-month period. Forty percent of the attacks resulted in some injury. (Grace Hechinger, How To Raise A Street-Smart Child, 1984)

CHILD SEXUAL ABUSE, INCLUDING SEXUAL EXPLOITATION, IS WIDESPREAD

* At least 22% of Americans have been victims of child sexual abuse -- 27% of women and 16% of men. Sexual intercourse was involved in 55% of the molestations and 39% of these incidents occurred repeatedly. Abusers were friends and acquaintances (42%), strangers (27%) and relatives (23%). (L.A. Times Poll, August 25, 1985)

* In 1983, 25% of the children reported as sexually abused were under the age of six. (American Humane Association, 1985)

MISSING CHILDREN OFTEN EXPLOITED

* Of the 1.5 million youth each year who run away or are homeless, 25% are hard core "street kids"; 75% engage in some type of criminal activity; and 50% engage in prostitution. (U.S. Department of Health and Human Services, October, 1983)

* In a study by The Louisville-Jefferson County (Kentucky) Exploited and Missing Child Unit, of 1,400 cases of children suspected of being victims of sexual exploitation between 1980 and 1984, 54% were found to have been exploited and 85% of these were missing from their families or guardians at the time of the exploitation. (John Rabun, Deputy Director, The National Center for Missing and Exploited Children, Testimony before the Senate Subcommittee on Juvenile Justice, "Effect of Pornography on Women and Children," October 18, 1984)

ESTIMATES ABOUT WHETHER TEENAGE PROSTITUTION IS INCREASING VARY

* A 1982 survey of 50 state officials and 22 city government and police officials shows survey respondents generally

agree juvenile prostitution has increased in recent years. (General Accounting Office, 1982).

* A recent report, based on direct field investigation, case review, and a survey of 596 police departments in 50 states, estimates the number of male and female prostitutes to be between 100,000 and 200,000. (Daniel Campagna and Donald Poffenberger, Sexual Exploitation of Children: Resource Manual, 1985)

* The same report states that of 596 police departments surveyed, 89 (38.6%) of those responding reported a recent increase in juvenile prostitutes and 116 (50.4%) reported a recent decrease. (Campagna and Poffenberger, Sexual Exploitation of Children: Resource Manual, 1985)

SEXUAL ABUSE AND EXPLOITATION AT HOME A FACTOR IN TEENAGE PROSTITUTION

* 31-66% of female and 10-29% of male teenage prostitutes are sexually abused by family members. (D. Kelly Weisberg, Children of the Night, 1985)

* 70-75% of both male and female teenage prostitutes come from homes where relationships with adults are characterized by neglect, alcoholism, abuse and hostility. (Weisberg, Children of the Night)

* Child sexual abuse is also a factor among pedophiles. The majority of child sex offenders, conservatively estimated at 80%, were sexually abused as children. (Nicholas Groth, Interview, Medical Aspects of Human Sexuality, May, 1985)

WHILE COMMERCIAL CHILD PORNOGRAPHY HAS DECREASED, SEXUAL EXPLOITATION OF YOUNG CHILDREN CONTINUES

* During the late 1970's, nearly 400 child pornography magazines were in circulation. (Los Angeles Times, September 16, 1985)

* Since passage of The Protection of Children Against Sexual Exploitation Act (P.L. 95-225) in 1978, which outlawed commercial production and distribution of child pornography, U.S. production of commercial child pornography decreased significantly. (Jack O'Malley, U.S. Customs Special Agent, Hearing before the Senate Permanent Subcommittee on Investigations, "Child Pornography and Pedophilia," November 29 and 30, 1984)

* Since passage of The Child Protection Act of 1984, (P.L. 98-292), which outlawed non-commerical distribution of child pornography, U.S. Customs has opened 166 investigations, resulting in 29 federal felony convictions and 38 state convictions. In 1983 there were 5 state convictions and 1 federal conviction. (Los Angeles Times, September 16, 1985)

* State, city, and police officials surveyed believe that the number of children involved in commercial and non-commercial pornography has increased or remained the same. (Government Accounting Office, April, 1982)

SUMMARY OF FULL COMMITTEE HEARING ON "CHILDREN AND FAMILIES IN POVERTY: BEYOND THE STATISTICS" WASHINGTON, D.C., NOVEMBER 6, 1985

Twenty-one percent (12.9 million) of the children in America are impoverished. The rate is higher for children under 6, and for black children under 6 the poverty rate exceeds 50 percent. The number of poor children has increased by 3 million since 1979.

The Select Committee on Children, Youth, and Families held a hearing on the problems of low-income families and children on November 6, 1985, in Washington, DC. The hearing was held at Friendship House, one of the oldest settlement houses in the Washington area. The hearing focused on the day-to-day struggles that low-income parents face in supporting their families, and the difficulties teenagers have growing up in low-income families.

Tweedy Williams and her one-year-old son, Bert, opened the hearing. She described her family's ritual of waiting for the mailman to deliver her check and, if the check was late, having to turn to neighbors and friends for food. More recently, she, with all the other tenants in her apartment building, was evicted, because the landlord had not paid the mortgage for two years. She and her infant then spent more than two months in a shelter for homeless families. Very recently she moved into an apartment in Southeast Washington, DC. However, she now must leave home at 6:00 a.m. in order to get to her job on time, and spends $4.80 per day for transportation. She is paid $4.00 per hour.

Aletha Harris, a single mother of four, is a full time employee of the National Institutes of Health, yet runs out of food nearly every month. After a five year wait, she was able to move her family into subsidized housing. At that time she had no car, and no access to public transportation. During that year she would often walk five miles for groceries, and a mile to drop her youngest child at day care. This year she has no phone because she had to pay off last winter's electric bill, and was not able to afford both. Although she works full time, she survives only with the help of her church and a few friends.

The final witness on the first panel, 17-year-old Michael Jacobs, spent his early years in a single-parent family, living in a tough neighborhood. He dropped out of high school because he was getting involved in drugs and was skipping school with his friends. He joined the Job Corps, but his attitude hadn't changed, so he was asked to leave. He has since, however, become much more positively motivated. This past spring he enrolled in the Center for Youth Services, and is currently studying for his GED. He plans to study electrical engineering in college next year.

Stephanie Epps, a 17-year-old mother of two, led the second panel. Ms. Epps was raised by her grandparents in North Carolina, and moved to the District in 1980. She now lives with her mother, sister, and her two sons, ages three and five months, in a three-room apartment. Her sister sleeps on the couch, and she and her mother share their beds with the children because there is not enough room to set up a crib. She often gets up at 2 a.m. to study, since that is the only undisturbed time available to her. Her youngest son is cared for in the Infant Care Center at Cardozo High School, where Ms. Epps is a student. It is the only on-site child care at any high school in the District of Columbia.

The next witness was Ana Moreno, a mother of four who came to the United States from El Salvador nearly 12 years ago. Mrs. Moreno works a few days a week as a domestic, and her husband has been working as a bus boy for the past six years. She told the members of the Committee that she would work more, but she cannot find, or afford, child care. She lost one of her jobs because her employer would no longer allow her to bring her youngest son with her to work. She, her husband, and three of their children share a one-bedroom apartment. Mrs. Moreno's oldest son, age 12, remains in El Salvador because she cannot afford to support him in this country. She was able to bring her second son, age 10, here only this year.

Joseph Citro, Executive Director of The Family Place, translated for Mrs. Moreno. Located in the Adam's Morgan area of Washington, DC, the Family Place is a neighborhood drop-in center for parents and young children. It provides a range of free services including, emergency assistance, information and referral, individual, educational and employment counseling, as well as help in securing needed social and medical services. The Family Place also sponsors the Better Babies program in Northeast Washington, which offers free services to help pregnant women have healthier babies. These services include help in getting prenatal care, free pregnancy testing kits, home visits, a drop-in center, and help in getting other services, such as transportation, Medicaid, and other social services.

Fred Taylor, Executive Director of For Love of Children (FLOC), a community organization whose purpose is to help children and families who are homeless, abused or neglected, spoke of the trends he has seen over the past 20 years. When FLOC first began its work in the District of Columbia, roughly half of the families seen were two-parent families. Today, nearly all the families assisted are female-headed. Mr. Taylor stressed the importance of entitlement programs, and urged Committee members to safeguard those programs. His experience has taught him that climbing out of poverty is possible but requires the consistent help and support of caring neighbors, a caring community, and a caring nation.

Ayo Handy, Director of Community Services at the Southeast Neighborhood House, concluded this panel. She spoke as a service provider and as someone who has lived in poverty. Ms. Handy also discussed the "feminization of poverty" and its causes, such as a high divorce rate, an increase in out-of-wedlock births, low wages, inadequate child care services and limited access to education and skills training. The Community Services staff of 5 serves an average of 400 people a month, providing employment, education, housing, counseling and crisis intervention services.

CHILDREN AND FAMILIES IN POVERTY
A FACT SHEET

Childhood Poverty Remains High

* In 1984, 12.9 million, or 21%, of all children in America were poor. 8.1 million of those children were white, 4.3 million were black and 2.3 million were Hispanic children (white and non-white). 6.7 million (52%) of these impoverished children were in female-headed, single-parent households. (Census Bureau, 1985)

* The poverty rate for children under age 6 was 23.4% in 1984. For black children under age 6, the poverty rate was 51.1%, the highest rate recorded for this group since the Census Bureau began collecting these data in 1970. (Census Bureau, 1985)

* The number of poor children increased by nearly 3.5 million between 1979 and 1983, and fell by 520,000 between 1983 and 1984. The decline between 1983 and 1984 was entirely among white children, although the poverty rate for white children, 16.1%, remains over 40% higher than in 1979. Poverty rates for black children remained at 46.2% between 1983 and 1984, and rose from 37.7% to 38.7% for Hispanic children. (Census Bureau, 1985)

* The increase in poverty among children since 1979 included over 2 million children in male-headed families. During that period, poverty rates in male-headed families climbed faster than in female-headed families. (Census Bureau, 1985)

* Between 1959 and 1969, the child poverty rate was cut in half to a record low of 13.8%. By 1984, the child poverty rate had risen 50% above its 1969 low. (Census Bureau, 1985)

Poverty Highest in Female-Headed and Minority Familes

* A child in a female-headed family is four times as likely to be poor as one in a male-present family. A black child is three times as likely to be poor as a white child. (Children in Poverty, Committee on Ways and Means, 1985)

* Forty-five percent of all poor white children, and 75% of all poor black children, live in female-headed, single-parent families. By 1990, 3 million more children under 10 will live in single-parent households, (totalling 38.8 million, a 48% increase in this decade) raising the percentage of children in such households to 23%. (Select Committee on Children, Youth, and Families, 1983 and Children in Poverty, 1985)

* Overall, 4.8% of children are "persistently" poor (poor 10 years or more during a 15 year period). However, nearly 30% of black children are persistently poor. Of all persistently poor children, almost 90% are black. (Children in Poverty, 1985)

Working Poor Families Try To Escape Poverty

* Nearly 40% of families receiving AFDC in 1982 reported earnings from income during that year. (Beyond The Myths, Center on Social Welfare Policy and Law, 1985)

* More than one-sixth of poor children in 1983, 2.5 million, were in families with at least one full-time, year-round worker. (Children in Poverty, 1985)

* One-fourth of children in married-couple families would be poor if their only income were their father's earnings. If the mother's earnings are also counted, the poverty rate for children in married-couple families is reduced to 17.2%, a 30 percent reduction. (Children in Poverty, 1985)

Higher Taxes and Erosion of Income Supports Leave Children More Deeply in Poverty

* In 1978, a family of four at the poverty line paid $403 in payroll taxes and received $134 in refundable Earned Income Tax credits for a total federal tax burden of $269. In 1984, a similar low-income family paid $711 in payroll taxes and $365 in income taxes for a total Federal tax burden of $1,076, an increase of 300%. (Joint Committee on Taxation, 1984)

* Between 1973 and 1983, the number of children in poverty increased by over 40%. During that time, aggregate government income supports to impoverished children, including AFDC and Social Security benefits, declined in real terms. The combined effect of declining real value of benefits, and increasing numbers of poor children, meant the average amount of support going to each child fell significantly. (Children in Poverty, 1985)

* The average number of poor children receiving AFDC benefits declined from 83.6 per 100 children in 1973 to 53.3 per 100 in 1983 because state income eligibility standards have not kept pace with inflation. (Children in Poverty, 1985)

* In 1984, the combined benefit from food stamps and AFDC was below the poverty level in every state except Alaska, and below 75% of the poverty level in almost four-fifths of the states. 50.3% of all Food Stamp recipients are children. (Committee on Ways and Means, 1985 and U.S. Department of Agriculture, 1982)

* Of the nearly 1 million women below the poverty level who were due child support payments in 1983, only 62% received any amount of payment. The average annual payment received was $1,430, about 60% of the average payment received by all women. The average total income of an impoverished mother with 3 children who received child support payments in 1983 was $5,423. (Census Bureau, 1985)

Poverty and Need in the Nation's Capital

* The poverty rate for children in Washington, D.C., 26%, was higher than the child poverty rate for any of the 50 states except Mississippi. (Census Bureau, 1980)

* In 1984, the infant mortality rate in Washington, D.C. was 20.6 per 100 live births, nearly twice the national average of 10.6 per 100 live births. (National Center for Health Statistics, 1985)

* In 1984, 93% of all teenage girls who gave birth in Washington were unmarried. (Washington D.C. Dept. of Human Services, 1985)

* The average annual unemployment rate in 1984 for all teenagers in Washington, D.C. was 36.5%; for black teenagers it was 40.5%. (Bureau of Labor Statistics, 1985)

SUMMARY OF FULL COMMITTEE HEARING ON "SUDDEN INFANT DEATH SYNDROME"
WASHINGTON, D.C., NOVEMBER 14, 1985

Sudden Infant Death Syndrome (SIDS) is the major cause of infant death beyond the first month of life. One in 500--a total of at least 6,000--of the infants born each year in the United States succumb to SIDS. Commonly called "crib death," SIDS occurs suddenly and without apparent cause, resulting in extreme family trauma and dislocation.

Although there is no known cause of SIDS, certain risk factors are known, such as maternal smoking and an environment of poverty.

The Select Committee on Children, Youth, and Families (with the Subcommittee on Census and Population of the Committee on Post Office and Civil Service and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce) held a hearing on Sudden Infant Death Syndrome on November 14, 1985, in Washington, D.C.

Jane Garcia, the grandmother of a SIDS victim, was the first witness. Mrs. Garcia described what has happened to her and her family since her grandson died from SIDS. She has become very involved in the work of the National SIDS Foundation, while her son and daughter-in-law have had a second child, whom they are struggling to raise in a non-overprotective way.

Marie A. Valdes-Dapena, M.D., a Professor of Pathology and Pediatrics at the University of Miami and the President and Chairman of the National SIDS Foundation, was the next witness. She highlighted recent research findings on SIDS, including those from the National Institute of Child Health and Human Development (NICHD) Multicenter Epidemiological Study of SIDS. Those findings strongly support the thesis that SIDS infants are not healthy at birth and do not experience normal early childhood development.

Although it has been shown that SIDS is more prevalent among black than white children, Valdes-Dapena said, "race, in itself, is irrelevant--but mother's welfare is critical."

She testified that the most promising area of research related to SIDS is in the area of the infant central nervous system, as many SIDS victims have been found to have "scarring" on their brain stems.

The research Valdes-Dapena says is needed now--on improving pediatricians' diagnostic capabilities on SIDS, developing a plan for prevention of SIDS, and for further investigating the infant central nervous system--is expensive. The decrease in funding for SIDS-specific research, from $2.704 million in 1980 to $657 thousand in 1984, is an obstacle to getting this research done.

The next witness was Frederick Mandell, Clinical Professor of Pediatrics at Harvard University and Vice Chairman of the National SIDS Foundation. Mandell said that SIDS is a unique condition, in its effect on parents, siblings, and even physicians. The training of physicians, however, and especially of pediatricians, fails to prepare them for the after effects of SIDS episodes on families.

He advocated more money for research and services, on behalf of the traumatized families with whom he has worked.

The last witness on the first panel was Charlotte Catz, Chief of the Center for Research on Mothers and Children of the National Institute of Child Health and Human Development, accompanied by Geraldine J. Norris, Director of the National SIDS Program of the Federal Division of Maternal and Child Health. Dr. Catz gave a short history of SIDS research and reported on recent and current activities of NICHD. These include the Multicenter Epidemiological Study of SIDS, the largest study ever done of SIDS infants, which is now in its 7th year, and an upcoming conference on the relationship between apnea, or episodic breathing failure, and infant monitors.

She said that the depletion of funds for SIDS-specific research has been offset by an increase in funding for research related to high-risk infancy and high-risk pregnancy, research bearing either a secondary or tertiary relation to SIDS. She also mentioned SIDS activities administered by other federal agencies and by many private groups.

The first witness on the second panel was Gayla Reiter, SIDS Parent and Legislative Coordinator for the Northern California Chapter of the National SIDS Foundation. Reiter said that, since the incorporation of funding for the National SIDS Program into the Maternal and Child Health Block Grant, in 1982, there have been staff cuts in the SIDS program in California and statistics on SIDS are no longer being gathered there. Michigan, New York, and Florida have discontinued services for SIDS families and there have been serious cuts in programs in Colorado and Utah.

Information and counseling for families, and public and professional educational programs on SIDS, have borne the brunt of cuts, she added.

On the national level, Reiter reported that the federal government is now paying less for primary research on SIDS than it has at any time since passage of the 1974 SIDS Act. In 1973, the federal government spent $603,575 on SIDS primary research, compared to $657,000 in 1984.

Carrie Sheehan, Western Regional Director of the National SIDS Foundation, was the next witness. Sheehan lost a daughter to SIDS 30 years ago. While generally pleased with the progress which has been made in medical understanding of SIDS and compassion toward SIDS parents, she is concerned that we may now be regressing.

Sheehan said that, under the MCH Block Grant, SIDS service programs in the states have faltered. She cited specific problems with service provision in New York, Texas, Montana and Washington, and spoke in favor of restoring categorical funding for SIDS services. Absent categorical funding for SIDS services, she advocated earmarking MCH funds for state SIDS programs.

Parker H. Petit, Chairman of the Board of Healthdyne, Inc. and President of the National Sudden Infant Death Syndrome Institute, was the final witness of the panel. Petit told the Committee that he founded Healthdyne, which makes infant monitoring systems for hospitals and homes, after he lost his second son to SIDS.

Petit said that infant monitoring systems are an important part of the clinical effort to prevent SIDS, but that too little is known about the systems.

He added that private and industry sources have not bridged the gap in SIDS research funding created by the curtailment of government funds in recent years, and that even though some private charitable sources have united on this issue, the need for funds will likely outpace their funding capability for some time.

Medicaid reimbursement rates for home health systems vary widely from state to state, and are quite low in some states. As a result, according to Petit, many home care providers and potential providers consider the business unprofitable, and leave or fail to enter it. With little home care available, high-risk infants may be hospitalized inappropriately, at exorbitant cost.

Jennifer and Ken Wilkinson, SIDS Parents from Falls Church, Va., opened the third panel. Their daughter, Larkin, died last Christmas, at 3 1/2 months of age. They related their feelings of grief, pain, and horror, and the effects of the incident on their whole family.

They said that their two older children showed signs of depression and fear, and that their marriage was placed under extreme stress which lingered long after the loss itself.

The final witnesses were Sherry and Ronn Waller, SIDS Parents from Dallas, Texas. The Wallers' baby boy died of SIDS earlier this year, at 3 1/2 months. Both parents were badly shaken by the event and are still stricken with grief. They blamed SIDS deaths on a lack of will and a resultant lack of money devoted to SIDS prevention.

SUDDEN INFANT DEATH SYNDROME
A FACT SHEET

SIDS IS THE MAJOR CAUSE OF INFANT DEATH AFTER THE FIRST MONTH OF LIFE

* One out of every 500 babies -- 5,000-6,000 -- die of SIDS each year. 91% of these deaths occur within the first 6 months of life, with occurrences clustered around the period from 2-4 months. (NIH, 1985; Reisinger)

* SIDS kills more children in the first year of life than child abuse, cystic fibrosis, car accidents, and cancer, combined. (National SIDS Foundation, 1985)

THE CAUSE OF SIDS IS UNKNOWN, BUT CERTAIN RISK FACTORS ARE KNOWN

Demographic Factors

* The incidence of SIDS is higher among children who are urban, black, male, twins, or premature. The incidence is also higher for infants born of teen parents, low income parents, and parents who do not complete high school. (Dr. Julius B. Richmond, Assistant Secretary for Health, Federal Department of Health, Education and Welfare, testimony before the Senate Subcommittee on Child and Human Development, "Sudden Infant Death Syndrome Act Extension, 1978," March 1, 1978.)

* In another study, it was found that racial differences in SIDS rates disappeared within an economic subgroup when rates were adjusted for family income. (Richmond, 1978)

Behavioral Factors

* Approximately 70% of the mothers of SIDS infants smoked during their pregnancies, as compared with about 40% of the mothers of the control infants. (NICHD, 1985)

* 36% of the black infants who developed SIDS had not had regular pediatric visits, as compared with 22% of the control group of black infants. (NICHD, 1985)

* In a study conducted in Sheffield, England, the single best predictor of death in infancy was the failure of the mother to bring the baby to the first follow-up clinic for postnatal care. (Protestus et al, 1973, cited in Guntheroth, 1982)

SIDS INFANTS OFTEN APPEAR NORMAL, BUT RECENT STUDIES SHOW THAT THEY HAVE PROBLEMS WHICH PREDATE THEIR DEATH

* In the largest study of SIDS to date, 24% of the infants who succumbed to SIDS had been considered low-birthweight, as opposed to 6.5% of the control group. (NICHD, 1985)

* Overall, 20% of SIDS victims are low-birthweight. (Reisinger)

* While most SIDS victims are not abnormally small at birth, they often lag in growth after birth, indicating some later developmental problem or problems. (Lipsitt et al, 1979; Naeye, 1980)

58-957 O - 86 - 3

* Sophisticated autopsies reveal that over half of the victims of SIDS exhibit the consequences, and what could be the cause of hypoxemia, or chronic lack of oxygen. (Naeye, 1980)

* 87% of SIDS babies have pinpoint hemmorhages, or petrechiae, in their chest organs, indicating that their respiratory tracts have been closing improperly at the end of breaths. (Beckwith, 1983)

* A large percentage of infants dying from SIDS have had very minor illnesses of some type within 2 weeks of their deaths. (Richmond, 1978)

LEGISLATIVE HISTORY OF SIDS

* In 1974, the SIDS Act authorized research under the National Institute on Child Health and Human Development, education of health and law enforcement personnel and the general public, and counseling and informaton services for the families of SIDS victims.

* In FY 1982, the budget authority for the SIDS information and counseling services was folded into the Maternal and Child Health Block Grant, and cut by 20%. Current funding for the Maternal and Child Health Block Grant is slightly above the FY 1981 level.

NICHD - National Institute on Child Health and Human Development
NIH - National Institutes of Health

LIST OF WITNESSES AND THOSE WHO SUBMITTED TESTIMONY FOR THE RECORD, 1985

ALCOHOL ABUSE AND ITS IMPLICATIONS FOR FAMILIES (3/18/85)

*Bland, John, Director, Alcoholism Control Administration, Department of Health and Mental Hygiene, Annapolis, Maryland
*Blume, Sheila B., M.D., Medical Director, Alcoholism and Compulsive Gambling Programs, and Member of the Board of Directors, Children of Alcoholics Foundation, Inc., Amityville, New York
*Burns, Carolyn, Vice President, Programs, National Federation of Parents for Drug-Free Youth, Silver Spring, Maryland
*Daigle, John, Vice Chairperson, Governor's Commission on Drug and Alcohol Concerns, and Executive Director, Florida Alcohol Drug and Abuse Association, Tallahassee, Florida
*Devine, Hon. Andy, Judge, Lucas County Court Of Common Pleas, Juvenile Division, Toledo, Ohio
Duffy, Ellen, CPC (Coordinating with the Professional Community) Coordinator, Alcohol Abuse and its Effects on the Family, Al-Anon Family Group Headquarters, Inc., New York, New York
*Faria, Beverly, Parent, Concord, California
Gulker, Virgil, D.A., Founder and President, LOVE, Inc., Church Services Networks, Holland, Michigan
Hawkins, Hon. Paula, a U.S. Senator from the State of Florida
*Kramer, Hon. Albert L., Presiding Justice, Quincy District Court, Quincy, Massachusetts
*Macdonald, Donald Ian, M.D., Administrator, Alcohol, Drug Abuse and Mental Health Administration, U.S. Department of Health and Human Services, Washington, D.C.
*Marjorie, Parent, Montgomery County, Maryland
*West, Bret, Student, Baton Rouge, Louisiana
*West, Don, Parent, Baton Rouge, Louisiana
*West, Dot, Parent, Baton Rouge, Louisiana
Williams, Carol N., Ph.D., Center for Alcohol Studies, Brown University, Providence, Rhode Island

FAMILIES WITH DISABLED CHILDREN: ISSUES FOR THE 1980'S (4/19/85)

Anderson, Betsy, Federation for Children with Special Needs, Boston, Massachusetts
*Bertaina, Beverly, Parent, Sebastopol, California
Birch, Thomas L., Legislative Counsel, National Committee for Prevention of Child Abuse, Washington, D.C.
Borman, Leonard D., Ph.D., President and Founder, the Self-Help Center, Evanston, Illinois
*Brees, Stephen, Consultant, Fountain Valley School District, Fountain Valley, California
Breslau, Naomi, Ph.D., Associate Professor of Sociology, Case Western Reserve University, Cleveland, Ohio
Bristol, Marie M., Ph.D., Senior Investigator, Research Assistant Professor, Division TEACCH, Department of Psychiatry, University of North Carolina, Chapel Hill, North Carolina
Burchill, Rhys, Huntington Beach, California
Burley, Margaret, Executive Director, Ohio Coalition for the Education of Handicapped Children, Worthington, Ohio

*Testified before the Select Committee.

*Butler, John A., Co-investigator, Collaborative Study of Children With Special Needs, the Children's Hospital Medical Center, Boston, Massachusetts
Cerrato, Mary C., Ph.D., Associate Professor of Pediatrics, Pediatric Psychology, University of Texas, Galveston, Texas
Chan, Sam, Ph.D., University Affiliated Program, Children's Hospital Of Los Angeles, Los Angeles, California
Chasen, Fran, Early Childhood Specialist, Director, Infant Development Program, Exceptional Children's Foundation, Los Angeles, California
Childers, Cathy Cook, Parent, North Carolina
Cohen, Shirley, Ph.D., Hunter College, United Cerebral Palsy Associations, Inc., New York, New York
Disability Rights Education and Defense Fund, Berkeley, California
Downes, Carolyn V., Parent, Garden Grove, California
Hailey, Jack, Executive Secretary, Child Development Programs Advisory Committee, Sacramento, California
Eirsch, Elaine, Chief, Disabled Persons Advocacy Division, Office of the Illinois Attorney General Neil F. Hartigan
LaMarche, Catherine, TASK Director, Team of Advocates For Special Kids, Orange, California
Lambert, Kay, Advocacy, Inc., Austin, Texas
*Latzko, Trudy, Program Director of Developmental Services Department, Family Service Agency of San Francisco, San Francisco, California
Palmer, William G., Doctoral Student in Counseling Psychology, University of the Pacific, Stockton, California
Perrin, James M., M.D., Senior Research Associate, Vanderbilt University, Nashville, Tennessee
*Poyadue, Florence M., Parent and Executive Director, Parents Helping Parents, Inc., San Jose, California
*Short, Mary K., Parent, Fountain Valley, California
Stein, Ruth, M.D., Director, Division of Pediatric Ambulatory Care, Bronx, New York
Turnbull, Ann P., Acting Associate Director, Bureau of Child Research, University of Kansas, Lawrence, Kansas
*Vincent, Lisbeth J., Associate Professor, Department of Studies in Behavioral Disabilities, University of Wisconsin, Madison, Wisconsin
W[illegible], Madeleine, Assistant Secretary, U.S. Department of Education, Washington, D.C.
Warren, Rachel, Program Consultant, United Cerebral Palsy Associations, Inc., New York, New York
*Ziegler, Martha, Parent and Executive Director, Federation for Children with Special Needs, Boston, Massachusetts

TAX POLICY: WHAT DO FAMILIES NEED? (4/24/85)

*Carleson, Robert B., Principal and Director of Government Relations, KMG Main Hurdman
Carlson, Allan C., Ph.D., Executive Vice President, the Rockford Institute, Rockford, Illinois
*Edelman, Marian Wright, President, Children's Defense Fund, Washington, D.C., accompanied by Mary Bourdette and James Weill
Kemp, Hon. Jack, a Representative in Congress from the State of New York
*Minarik, Joseph J., Senior Research Associate, the Urban Institute, Washington, D.C.
*Moynihan, Hon. Daniel Patrick, a U.S. Senator from the State of New York

National Tax Association--Tax Institute of America (Publisher)
Regier, Gerald P., Chairman, Committee on Tax Fairness for Families, President, Family Research Council of America, Inc., Washington, D.C.
*Schorr, Alvin L., Leonard W. Mayo Professor, Case Western Reserve University, Cleveland, Ohio

PREVENTION OF ALCOHOL ABUSE IN AMERICAN FAMILIES (5/2/85)

*Burcham, John B., Chairman, Licensed Beverage Information Council, Washington, D.C., accompanied by Paul Gavaghan, Secretary-Treasurer, Licensed Beverage Information Council
Burton, Hon. Dan, a Representative in Congress from the State of Indiana
*Duvall, Hon. Howard E., Mayor, Cheraw, South Carolina
*Hewlett, Augustus H., President Alcohol Policy Council, Waterford, Virginia, Representing the National Association of Broadcasters
*Jacobson, Michael F., Ph.D., Executive Director, Center for Science in the Public Interest, Washington, D.C.
*Kaplan, Constance, student assistance counselor
Metz, Douglas W., Executive Vice President and General Counsel, Wine and Spirits Wholesalers of America, Inc., Washington, D.C.
*Mosher, James F., Associate Director For Policy Studies, Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California
*Regnery, Alfred S., Administrator, Office of Juvenile Justice and Delinquency Prevention, Department of Justice, Washington, D.C.
*Reid, Tim, Actor, and Board Director, Entertainment Industries Council, McLean, Virginia
*Rusche, Susan, Columnist, King Features, and Executive Director, "Families in Action," Atlanta, Georgia
*Sanders, Doreen, Student Assistant Counselor, Westchester County Department of Mental Health, Westchester, New York
Schneider, Patricia, Education Director, Wine Institute, San Francisco, California
Summers, John B., Executive Vice President, National Association of Broadcasters, Washington, D.C.
*Swift, Hon. Al, a Representative in Congress from the State of Washington
*Wenger, Sis, Alcohol and Drug Education Consultant, Southeast Michigan School District, Birmingham, Michigan

EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS (6/6/85)

*Concannon, Kevin W., Commissioner, Maine Department of Mental Health and Mental Retardation, Augusta, Maine
Cutler, Jay B., Special Counsel and Director, Division of Government Relations, American Psychiatric Association, Washington, D.C.
*DeFoe, Barbara, Parent, Coon Rapids, Minnesota
*DeFoe, Marissa, [age 15], Daughter of Barbara DeFoe
*Egan, Dr. James, Chairman, Department of Psychiatry, Children's Hospital National Medical Center, Washington, D.C.
Johnson, Bill, Manager, Lay Advocates Network of the Mental Health Association of Minnesota

Lourie, Ira S., M.D., Child and Adolescent Service System Program, Underserved Populations Branch, Office of State and Community Liaision, National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services, Washington, D.C.
*Richard, Albert, Jr., Chief Juvenile Probation Officer, Dallas County, Texas
*Schlesinger, Mark, Ph.D., Research Coordinator, Center for Health Policy and Management, John F. Kennedy School of Government, Harvard University, Boston, Massachusetts
*Schwartz, Ira M., Senior Fellow and Director, Center for the Study of Youth Policy, Hubert H. Humphrey Institute of Public Affairs, University of Minnesota
The National Association of Private Psychiatric Hospitals, Washington, D.C.

LEARNING FROM THE PRIVATE SECTOR: A DIALOGUE WITH FOUNDATION EXECUTIVES (6/27/85)

*Bondurant, William L., Executive Director, Mary Reynolds Babcock Foundation, Winston-Salem, North Carolina
*Forsythe, Peter, Vice President, Edna McConnell Clark Foundation, New York, New York
*Hamburg, David A., M.D., President, Carnegie Corporation of New York, New York
*Hearn, Ruby P., Ph.D., Vice President, The Robert Wood Johnson Foundation, Princeton, New Jersey
*Smith, Leonard W., President, The Skillman Foundation, Detroit, Michigan
*Wilson, Kirke, Executive Director, Rosenberg Foundation, San Francisco, California

CHILD CARE: THE EMERGING INSURANCE CRISIS (7/18/85)

Bunner, Bruce, State Insurance Commissioner, Department of Insurance, Los Angeles, California
*Chastain, James, Professor of Insurance, Howard University, Director, Center for Insurance Education, Washington, D.C.
*Chessnoe, Alyce M., Family Day Care Provider, Burke, Virginia, President, Northern Virginia Family Day Care Association
*Florio, James J., a Representative in Congress from the State of New Jersey
Gejdenson, Sam, a Representative in Congress from the State of Connecticut
*Gellert, Sandra, President, National Association of Family Day Care, Clifton Heights, Pennsylvania, accompanied by Lori Weinstein, Director, Family Day Care Project Children's Foundation, Washington, D.C.
New York State Child Care Coordinating Council, Hempstead, New York
*Phillips, Deborah, Ph.D., Director, Child Care Information Service, National Association for the Education of Young Children, Washington, D.C.
*Silverman, Joseph S., Executive Vice President, BMF Marketing Insurance Services, Inc., Sherman Oaks, California
*Solon, Karen E., Family Day Care Provider, Falls Church, Virginia
*Weaver, Jean, Day Care Coordinator, YWCA, Baltimore, Maryland, President, Maryland Child Care Association
*Yocum, Georgia D., Chief Executive Officer, Loma Rica Insurance Agency, Grass Valley, California

CHILD CARE: THE EMERGING INSURANCE CRISIS, PART II (7/30/85)

*Birch, Thomas L., Legislative Counsel, National Child Abuse Coalition, Washington, D.C.
Child Care Law Center, San Francisco, California
*Hunter, J. Robert, President, National Insurance Consumer Organization, Alexandria, Virginia
*Kimble, James L., Senior Counsel, Federal Affairs, American Insurance Association, Washington, D.C.
Meotti, Michael P., General Counsel, Insurance Association of Connecticut, Hartford, Connecticut
*Muhl, Hon. Edward J., Insurance Commissioner, State of Maryland, on behalf of the National Association of Insurance Commissioners
*Neuhauser, Frank, Jr., Vice President and Actuary, AIG Risk Management, Inc., New York, New York
*Nystrom, Hon. Peter, Representative, General Assembly, State of Connecticut,
*Walters, Mavis A., Senior Vice President, Insurance Services Office, Inc., Washington, D.C.

THE MELTING POT: FACT OR FICTION? (9/26/85)

*Bouvier, Leon, Ph.D., Vice President, Population Reference Bureau, Washington, D.C.
Hakuta, Kenji, Ph.D., Department of Psychology, Yale University, New Haven, Connecticut
*Hammond, Ray, M.D., Executive Director, The Efficacy Committee, Inc., Somerville, Massachusetts
*Harjo, Suzan Shown, Executive Director, National Congress of American Indians, Washington, D.C.
Hernandez, Jose, Professor, Department of Black and Puerto Rican Studies, Hunter College of the City University of New York, New York
Higginbotham, Elizabeth, Department of Sociology and Social Work and the Center for Research on Women, Memphis State University, Memphis, Tennessee
*McAdoo, Harriette P., Professor, School of Social Work, Howard University, Washington, D.C.
*Sassen-Koob, Saskia, Ph.D., Associate Professor, School of Architecture and Planning, Columbia University, New York, New York
*Swinton, David, Ph.D., Director, Southern Center for Studies in Public Policy, Clark College, Atlanta, Georgia
*Vu-Thu-Trang, Daughter
*Vu-Van-Ngo, Father, accompanied by Kim Cook, M.S.W., Executive Director, Mutual Assistance Association Consortium of Northern Virginia

CHILD VICTIMS OF EXPLOITATION (9/31/85)

*Berg, Thomas S., Director of Clinical Services, Chesapeake Institute, Kensington, Maryland
*Finkelberg, Steven, Detective, Metropolitan Police Department, Washington, D.C.
*Jupp, Michael, Executive Director, Defense for Children International- U.S.A., Brooklyn, New York
*Lanning, Kenneth V., Special Agent, Behavioral Science Unit, Training Division, Federal Bureau of Investigation, Washington, D.C.

*McCain, Hon. John, a Representative in Congress from the State of Arizona
Schram, Donna D., Ph.D., Urban Policy Research, Seattle, Washington
Stark, Hon. Fortney H. (Pete), a Representative in Congress from the State of California
*Taylor, Bruce A., Vice President--General Counsel, Citizens for Decency Through Law, Phoenix, Arizona
*Wagner, Victoria A., Executive Director, Seattle Youth and Community Services, Seattle, Washington

CHILDREN AND FAMILIES IN POVERTY: BEYOND THE STATISTICS (11/6/85)

Day, Nancy, Parent, Washington, D.C.
*Epps, Stephanie, Age 17, Washington, D.C.
Ferrell, Katherine, Kenilworth/Parkside Resident Management Corporation, Washington, D.C.
*Handy, Ayo, Director of Community Services, Southeast Neighborhood House, Washington, D.C.
*Harris, Aletha, Parent, Maryland
*Jacobs, Michael, Age 17, Oxon Hill, Maryland
*Moreno, Ana, Washington, D.C., accompanied by Joseph Citro, M.S.W., Executive Director, The Family Place, Washington, D.C.
*Taylor, Fred, Executive Director, For Love of Children (FLOC), Washington, D.C.
*Williams, Tweedy, Parent, Washington, D.C.
Williams, Lorrie, Member, Center for Youth Services, Washington, D.C.

SUDDEN INFANT DEATH SYNDROME (11/14/85)

*Catz, Charlotte S., Chief, Pregnancy and Perinatology Branch, Center for Research for Mothers and Children, National Institute of Child Health and Human Development (NIH), Bethesda, Maryland, accompanied by Geraldine J. Norris , Director, National SIDS Program, Federal Division of Maternal and Child Health, Washington, D.C.
*Garcia, Jane, Grandmother of a SIDS Victim, Bronx, New York
Lipsitt, Lewis P., Professor of Psychology and Medical Science, Brown University, Director, Child Study Center, Brown University, Providence, Rhode Island
*Mandell, Frederick, Clinical Associate Professor of Pediatrics, Harvard University, Boston, Massachusetts, Vice Chairman, National SIDS Foundation, Cambridge, Massachusetts
*Petit, Parker H., Chairman of the Board, Healthdyne, Inc., Marietta, Georgia
*Reiter, Gayla, SIDS Parent, Legislative Coordinator, Northern California Chapter of the National SIDS Foundation, Pacifica, California
*Sheehan, Carrie, Western Regional Director, National SIDS Foundation, Seattle, Washington
*Valdes-Dapena, Marie A., M.D., Professor of Pathology and Pediatrics, University of Miami, Miami, Florida, Chairman and President, National SIDS Foundation, Landover, Maryland
*Waller, Ronn, SIDS Parent, Dallas, Texas
*Waller, Sherry, SIDS Parent, Dallas, Texas
*Wilkinson, Jennifer, SIDS Parent, Falls Church, Viginia
*Wilkinson, Ken, SIDS Parent, Falls Church, Virginia

EXCERPTS FROM THREE OF THE REPORTS ISSUED IN 1985

Opportunities for Success: Cost-Effective Programs for Children

Tax Policy: How Do Families Fare?

Teen Pregnancy: What Is Being Done? A State-By-State Look

OPPORTUNITIES FOR SUCCESS:

COST-EFFECTIVE PROGRAMS FOR CHILDREN

A Bipartisan Staff Report Of The House Select Committee
On Children, Youth, and Families

George Miller, Chairman
Dan Coats, Ranking Minority Member

August 14, 1985

TABLE OF CONTENTS

	PAGE
Introduction	i
Highlights of Program Effects	ii
Programs	
Special Supplemental Food Program for Women, Infants and Children (WIC)	1
Program and Benefits	1
Studies	2
Prenatal Care	5
Program and Benefits	5
Studies	6
Medicaid	9
Program and Benefits	9
Studies	10
Childhood Immunization	12
Program and Benefits	12
Studies	13
Preschool Education	17
Program and Benefits	17
Studies	18
Compensatory Education	22
Program and Benefits	22
Studies	23
Education For All Handicapped Children	26
Program and Benefits	26
Studies	27
Youth Employment and Training	29
Program and Benefits	29
Studies	30
Appendix: Program Participation Sources	34

INTRODUCTION

This report demonstrates the proven success and cost-effectiveness of eight major children's programs. It provides proof of our ability to improve the lives of millions of vulnerable American children, while reducing the need for later and more costly expenditures.

The fact is that we already know enough to use public policy to benefit children, and do so in a way that returns funds to the federal treasury. We have been able to reduce infant mortality, overcome early learning deficiencies, and provide early educational access for handicapped children, among other examples.

We have not, however, reached millions of the children and families who are eligible for, and could benefit from, these programs. By not reaching out to the unserved children, we are foregoing opportunities for new successes as well as burdening future taxpayers with more costly public expenditures.

Our findings have been drawn from the most current and complete evaluations and research reviews available, most having been completed in the last five years. While we have described the most dramatic findings, in every case they are fully consistent with the weight of the evidence available.

While the programs identified in this report have proven their cost-effectiveness, this does not mean that other programs have not. Some simply have not been evaluated to the extent these have, or in a manner that lends itself to such an analysis. Some programs are too new for adequate longitudinal evaluations to have been completed. Still others have been studied and their effectiveness in meeting specific needs of children and youth has been demonstrated. Since they have not been evaluated strictly for the fiscal savings they effect, we have not included them in this report.

We acknowledge the methodological limitations present in evaluating all programs, including social programs. However, we believe it is extremely important to evaluate the effectiveness of publicly supported programs. In addition to enhancing our understanding of their impact on children and their budgetary implications, program evaluations also help us improve program design and delivery, and there are no programs that cannot be improved.

When the evaluations prove to be as positive as those found in this report, especially during a period of limited federal resources, we should use them to point the way to additional opportunities for sound investments in America's children and their families.

HIGHLIGHTS OF PROGRAM EFFECTS

	BENEFITS FOR CHILDREN	COST BENEFIT
WIC -- SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN	Reduction in infant mortality and births of low birthweight infants	$1 investment in prenatal component of WIC has saved as much as $3 in short-term hospital costs
PRENATAL CARE	Reduction in prematurity, low birthweight births and infant mortality	$1 investment can save $3.38 in cost of care for low birthweight infants
MEDICAID	Decreased neonstal and infant mortality, and fewer abnormalities among children receiving EPSDT services	$1 spent on comprehensive prenatal care added to services for Medicaid recipients has saved $2 in infant's first year; lower health care costs for children receiving EPSDT services.
CHILDHOOD IMMUNIZATION	Dramatic declines in incidence of rubella, mumps, measles, polio, diphtheria, tetanus and pertussis	$1 spent on Childhood Immunization Program saves $10 in later medical costs
PRESCHOOL EDUCATION	Increased school success, employability and self esteem; reduced dependence on public assistance	$1 investment in quality preschool education returns $4.75 because of lower costs of special education, public assistance, and crime
COMPENSATORY EDUCATION	Achievement gains and maintenance of gains in reading and mathematics	Investment of $500 for year of compensatory education can save $3000 cost of repeating grade
EDUCATION FOR ALL HANDICAPPED CHILDREN	Increased number of students receiving services and more available services	Early educational intervention has saved school districts $1560 per disabled pupil
YOUTH EMPLOYMENT AND TRAINING	Gains in employability, wages, and success while in school and afterwards	Job Corps returned $7,400 per participant, compared to $5,000 in program costs (in 1977 dollars). FY 1982 service year costs for YETP were $4700; participants had annualized earnings gains of $1810.

PROGRAM	PARTICIPATION
WIC - SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN	3.1 million participants -- about 1/3 of those potentially eligible -- received WIC services in Spring 1985.
PRENATAL CARE	23.9% of live births in 1982 were to mothers who did not begin prenatal care in the first trimester of pregnancy. The rate for white births was 20.7%, for black births 38.5%.
MEDICAID	In FY 1983 an estimated 9.5 million dependent children under 21 were served by Medicaid, including 2.2 million screened under EPSDT. In calendar 1983 there were 14.3 million related children in families below the poverty line.
CHILDHOOD IMMUNIZATION	An estimated 3.4 - 3.8 million children were immunized with vaccine purchased under the Childhood Immunization program in FY 1983. In 1983 the total percent of children, ages 1-4, immunized against the major childhood diseases ranged from 74.4 for mumps to 86.0 for diphtheria-tetanus-pertussis. For those 5-14, percent immunized ranged from 86.2 for mumps to 92.9 for DTP.
PRESCHOOL EDUCATION	In 1983, there were 10.2 million children ages 3-5. 5.4 million of them were enrolled in public and non-public pre-primary programs. 442,000 children -- fewer than 1 out of every 5 eligible -- now participate in Head Start.
COMPENSATORY EDUCATION	In 1982-83 4.7 million children -- an estimated 50% of those in need -- received Chapter I services under the LEA Basic Grant Program.
EDUCATION FOR ALL HANDICAPPED CHILDREN	During 1983-84 4,094,108 children ages 3-21 were served under the State Grant program. The prevalence of handicaps in the population under age 21 is estimated to be 11.4% (9.5-10 million children).
YOUTH EMPLOYMENT AND TRAINING	Between October 1983 and July 1984, 83,426 youth were enrolled in Job Corps, and about 240,000 in JTPA Title IIA; 753,000 youths participated in the summer youth program in 1984. The annualized number of unemployed persons 16-21 years old in 1984 was 2,278,000.

TAX POLICY: HOW DO FAMILIES FARE?

A REPORT
OF THE

SELECT COMMITTEE ON CHILDREN,
YOUTH, AND FAMILIES

NINETY-NINTH CONGRESS

FIRST SESSION

OCTOBER, 1985

CONTENTS

	Page
Introduction	1
Families and Taxes: An Overview	
Women and Families as Taxpayers: A History[1] (Rosemary Marcuss and Rosemarie M. Nielson, Congressional Budget Office)	4
The Tax Treatment of Households of Different Size (Eugene Steuerle, Department of the Treasury)	24
Federal Tax Policy and the Family: The Distribution of the Dependent Exemption, the Child and Dependent Care Tax Credit, and the Earned Income Credit by Adjusted Gross Income Class, Tax Year 1982 (Stacy M. Kean, Congressional Research Service)	45
Families and Tax Reform	
Tax Reform and the Family[1] (Geraldine Gerardi and Eugene Steuerle, Department of the Treasury)	51
Family Characteristics and Horizontal Equity: A Comparison of Three Tax Reform Proposals (Gregg Esenwein, Congressional Research Service)	67
Implications of Tax Alternatives for Families: How Ten Families Fare Under Five Tax Proposals[1] (Martha M. Phillips, Committee on Ways and Means)	77
Alternative Approaches to Tax Reform: Income Supports for Families	
Financial Help for Vulnerable Families: The Income Transfer Menu[1] (Alfred J. Kahn, Columbia University)	137
A Critique of the Value Added Tax As It Affects Families	
The Incidence of a Value-Added Tax on the Family (James M. Bickley, Congressional Research Service)	155

[1] Papers presented at a conference, "Federal Tax Policy: What's In It For Women and Families", sponsored by the Women's Research and Education Institute in cooperation with the Family Impact Seminar.

INTRODUCTION

The current tax system requires the average American family with children to pay over $7,000 in taxes each year, more than half of which go to federal income taxes.* In addition, certain fundamental family matters including family formation, employment, and child care, carry with them important tax considerations as a result of specific tax provisions now in place.

For these reasons, and because tax reform is more than ever under consideration, we believe the tax system should be seriously analyzed from the point of view of its impact on families and the children who live in them. The eight papers included in "Tax Policy: How Do Families Fare?", bring us much closer to that goal.

Among the many critical family/tax related questions addressed in these papers are:

Since 1913, when the first permanent income tax was enacted, how have tax laws affecting families evolved in response to changes in economic and demographic conditions? [Women and Families as Taxpayers: A History (Rosemary Marcuss and Rosemarie Nielson, CBO)]

Relative to prior years, does the current tax code penalize families with children? [The Tax Treatment of Households of Different Size (Eugene Steuerle, from "Taxing the Family," American Enterprise Institute for Public Policy Research, 1983)]

At what level of income do families make the greatest use of the child care credit? [Federal Tax Policy and the Family: The Distribution of the Dependent Exemption, The Child and Dependent Care Tax Credit, and the Earned Income Credit by Adjusted Gross Income Class, Tax Year 1982 (Stacey Kean, CRS)]

Will families with incomes below the poverty line continue to be subjected to income tax? [Tax Reform and the Family (Geraldine Gerardi and Eugene Steuerle, Department of the Treasury)]

Under current law and in the various reform proposals, are married couples penalized relative to single taxpayers? Are single heads of household penalized relative to married couples? Are two-earner couples penalized relative to one-earner families? [Family Characteristics and Horizontal Equity: A Comparison of Three Tax Reform Proposals (Gregg Esenwein, CRS)]

Are large families treated equitably in relation to smaller families? [Family Characteristics and Horizontal Equity: A Comparison of Three Tax Reform Proposals (Gregg Esenwein, CRS)]

Will decisions to enter or leave the work force be affected? [Implications of Tax Alternatives for Families: How Ten Families Fare Under Five Tax Proposals (Martha Phillips, Committee on Ways and Means)]

---

* In 1983, mean pre-tax income for married couple families with children was $31,841; mean after-tax income was $24,824. (Bureau of the Census)

Will changes in the tax treatment of dependent care costs affect all families' ability to meet child care expenses equally? [Implications of Tax Alternatives for Families: How Ten Families Fare Under Five Tax Proposals (Martha Phillips, Committee on Ways and Means)]

Beyond the current tax reform debate, how do our tax and income transfer systems compare to those in other countries? [Financial Help for Vulnerable Families: The Income Transfer Menu (Alfred Kahn, Columbia University)]

And, finally, would a new "value added tax" treat all families fairly? [The Incidence of a Value-Added Tax on the Family (James Bickley, CRS)]

We would caution against drawing final conclusions regarding the total effectiveness of each reform proposal based on these analyses alone. These papers focus on those tax provisions which most directly affect families and children. The provisions important to families will interact in complex ways with all the other provisions in each proposal, and no conclusions should be drawn without looking at the entire proposal.

Finally, these papers do not include any analysis of the most recent Administration proposal, Treasury II, which appeared subsequent to our request for these papers. Also, some of the reform proposals which are included have since been modified, which we have noted where appropriate.

We are grateful to the Women's Research and Education Institute (WREI) for making available four of the papers that appear here, which were originally presented at a conference, "Federal Tax Policy: What's In It For Women and Families," sponsored by WREI in cooperation with the Family Impact Center. The other three papers were commissioned by the Select Committee on Children, Youth, and Families from the Congressional Research Service.

TEEN PREGNANCY: WHAT IS BEING DONE?

A STATE-BY-STATE LOOK

A REPORT
OF THE

SELECT COMMITTEE ON CHILDREN,
YOUTH, AND FAMILIES

NINETY-NINTH CONGRESS
FIRST SESSION

DECEMBER, 1985

TEEN PREGNANCY: WHAT IS BEING DONE?

A STATE-BY-STATE LOOK

TABLE OF CONTENTS

	Page
INTRODUCTION	ix
FINDINGS	xiii
LETTER TO GOVERNORS	xv
Chapter I: National Perspectives on Adolescent Pregnancy and Parenting	1
Birth Rates to Teens Have Declined; Pregnancy Rates Have Increased. Still, One-half Million Teens Give Birth Each Year. Most Remain at Greater Social and Economic Risk	2
Birth Rates Vary Depending on Age of Mother	3
Births to Unmarried Teens Continue to Grow	3
Birth Rates Vary for White/Minority Teens	4
Overall Teenage Pregnancy Rates Rose During the 1970's, But Have Slowed Since 1979	4
Sexual Activity Among Female 15-19 Year Olds Increased Dramatically in the 1970's, But Has Leveled Off Since 1979	6
Federal, State, and Local Expenditures for Teen Pregnancy and Parenthood Remain Very High	7
Health: Teen Mothers Receive Inadequate Prenatal Care; Infants Born to Teen Mothers Less Healthy	9
Early Prenatal Care Declines	10
Mortality More Likely for Infants of Teens	11
Low Birthweight Rates Greater for Infants of Teens	12
Education and Income: Teen Parents Are At Higher Risk of Poverty, School Failure and Unemployment	13
School Completion Extremely Low for Pregnant and Parenting Teens	13
Joblessness, Poverty, the Norm for Teen Parents	14
Teen Parents Suffer Higher Rates of Marital Instability, and Their Children Are More Likely Than Other Children to Have Health and Learning Problems, and To Be Teen Parents Themselves	16
Teen Parents Have Higher Rates of Divorce	16
Economic Support, Involvement By Teen Fathers Inadequate	16
Children of Teen Parents Are Less Healthy	17
Adoption, An Alternative to Teen Parenting, Declines	18
Figure 1. Adolescent Pregnancy Rate and Outcomes, 1970-1982	20
Figure 2. Adolescent Birthrates, 1970-1982	21

Table 1. Number of Births to Adolescents by Age of Mother 22

Table 2. Birth Rates by Age of Mother and Race of Child: U.S., 1970-1983 23

Table 3. Birth Rates for Unmarried Women Age 15-19 by Race of Child 24

Table 4. Live Births by Month of Pregnancy Prenatal Care Began for Women Age 15-19 25

Table 4A. Percent of Live Births to Adolescent Women Receiving Prenatal Care in First Trimester, by State 26

Table 5. State Infant Mortality Rates By Age of Mother 27

Table 6. Percent of Low Birthweight by Age of Mother 30

Table 6A. Percentage of Teen Births Which Are Low Birthweight, by State and Age of Mother 31

Figure 3. Percent Low Birth Weight, by Age and Marital Status of Mother, 1982 35

Figure 4. Percent of Mothers Who Are High School Graduates by Marital Status, 1982 36

Figure 5. Birth Rates for Unmarried Women Aged 15-17 and 18-19, 1970-82 37

Chapter II: Barriers to Serving At-Risk, Pregnant and Parenting Teens 38

States Identify Need for More Education, Public Awareness and Community Involvement 39

Examples of State Responses Regarding Education 39

States Lack Coordination Among Existing Services 42

Examples of State Responses Regarding Coordination of Services 43

States Have Insufficient Funds to Reach Teens in Need 45

Examples of State Responses Regarding Funds 46

States Collect Inadequate Data to Develop Effective Programs ... 47

Examples of State Responses Regarding Data 48

States Seek More Emphasis on Preventive Services 49

Examples of State Responses Regarding Prevention 50

States Have Substantial Service Gaps and Inaccessible Services . 51

Examples of Gaps in Current Services 51

Examples of Inaccessible Services 53

Chapter III: Federal Policies and Programs, and State Efforts 56

Federal Programs Undergird State Efforts 56

States Use Only Small Percent of Federal Funds for Adolescents 56

Application of Federal Services and Policies Varies Across States 57

Adolescent Family Life Projects 58

Additional Adolescent Family Life Act-Related Comments 58

Adoption Assistance 58

The Education Consolidation and Improvement Act (Chapter 1) .. 59

Additional ECIA-Related Comments 59

Family Planning 59

Additional Family Planning-Related Comments 61

The Job Training Partnership Act 61

Additional Employment-Related Comments 61

Maternal and Child Health Block Grant 62

Additional Health-Related Comments 64

Medicaid 64

Additional Medicaid-Related Comments 65

The Special Supplemental Food Program for Women, Infants and Children (WIC) 65

Additional WIC-Related Comments 65

Carl D. Perkins Vocational Education Act 66

Additional Vocational Education-Related Comments 67

Parental Involvement Central to all Programs 67

Parental Involvement 68

Parental Notification/Consent 68

Recent Changes in Federal Policy Have Affected the States' Ability to Serve the At-Risk Adolescent Population 70

AFDC Changes Undermine Support for Low-Income Teen Parents 70

Additional AFDC Comments 73

Medicaid Changes Enhance Preventive Health Services for Teen Mothers and Their Infants 74

Table 7. State-By-State Comments Regarding Selected Federal, State, and Local Programs 76

Table 8. Federal Funding for Pregnant, Parenting and All Adolescents (As Reported by States) 97

Chapter IV. State Efforts to Serve At Risk, Pregnant and Parenting Teens 110

Recent Initiatives in A Few States Hold Promise of Comprehensive, Coordinated Services..... 110

Improved Comprehensiveness, As Well As Improved Health, Education and Employment Services Are Common Themes 111

States Report Range of Local and Community-Based Programs 112

School-Based Programs 112

Community-Based Programs 115

Targeting Adolescent Males and Young Fathers 116

Public Awareness 118

Child Care 119

State Fact Sheets: A compilation of State responses including demographics, health, education, and economic indicators, adoption and foster care, agencies and departments, programs and resources, and statewideinitiatives and recent policy changes 120

APPENDICES

Appendix I: Questionnaire Submitted to Governors, and Accompanying National Data..... 291

Appendix II: Rate of Response to Selected Survey Questions.... 321

Appendix III: References Including All Documents Submitted By States..... 324

Appendix IV: Federal Program Descriptions..... 335

Appendix V: Adolescent Family Life Grantees by State - 1985 .. 348

ADDITIONAL VIEWS

Additional Views of Hon. George Miller, Chairman; Hon. William Lehman; Hon. Patricia Schroeder; Hon. Matthew F. McHugh; Hon. Ted Weiss; Hon. Beryl Anthony, Jr.; Hon. Barbara Boxer; Hon. Sander M. Levin; Hon. Bruce A. Morrison; Hon. J. Roy Rowland; Hon. Gerry Sikorski; Hon. Alan Wheat; Hon. Matthew G. Martinez; Hon. Lane Evans; Hon. Hamilton Fish, Jr.;Hon. Nancy L. Johnson..... 354

Additional Views of Hon. Nancy L. Johnson; Hon. Hamilton Fish, Jr. 369

MINORITY VIEWS

Minority Views of Hon. Dan Coats, Ranking Minority Member; Hon. Thomas J. Bliley, Jr.; Hon. Dan Burton; Hon. Barbara F. Vucanovich; Hon. David S. Monson; Hon. Robert C. Smith ... 373

INTRODUCTION

Helping to prevent pregnancies among young teens, and reducing the social and economic risks for teenage parents and their children, remains a very serious challenge to this nation.

We have failed to take up that challenge in an effective or comprehensive manner, either at the national, or as this report will document, at the State and local level.

This report is an effort to help us meet that challenge.

Our findings are reason for very real concern for the teenagers, for their children, and for the nation.

It is clear from this report that there is no focused approach to solving the complex problems of teen pregnancy at any level of government. The efforts that do exist are too few, uncoordinated, and lack significant support. In short, the system is broken.

Regardless of one's political philosophy, the prospect of one million teenage pregnancies, 400,000 abortions, and one-half million births each year, nearly fifty-five percent of which will be births to unmarried teens, is chilling. The human and fiscal costs to all are unacceptable.

For the teens, and their children, prospects for a healthy and prosperous life are significantly reduced.

The infants are at far greater risk of low birthweight and therefore infant mortality.

The mothers, because of poor nutrition and inadequate health care, are themselves at greater risk of poor health. We also know that one-third of these mothers will have a subsequent pregnancy while still in their teens.

The problems and risks for both pregnant teenagers and teen parents -- mothers and fathers alike -- are compounded by the fact that they are much more likely to drop out of high school before graduation. For teens who do get married, studies also confirm that they will experience higher rates of marital instability.

The result of successive risk factors such as these is often poverty, for both teen mothers and their infants. One half of this nation's Aid to Families with Dependent Children (AFDC) budget is spent on families begun when the mother was an adolescent.

These conditions, and their consequences for the teenagers, their infants, and for government, have been a major concern of the Committee.

We have surveyed the Governors of every State to determine exactly what data are available regarding teen pregnancy and parenting in their State. Although States' responses to our questionnaire, mailed on February 7, 1985, varied enormously, all but one of the 50 States cooperated with our survey.

We have sought States' views about the impact of current policies and programs. We have sought information regarding their

needs, services, special projects, and initiatives. And we have asked about barriers to successful programs, as well as for recommendations on how to improve current efforts.

In this report, we have been careful to let the States speak for themselves as often as possible, both with regard to comments and data. Our conclusions are based on their responses to our survey questionnaire, in whatever form they were submitted. In a few instances, we are aware of more recent State actions or studies. If, however, this information was not reported to us in response to our questionnaire, we have not included it.

We have attempted to build an information base which will help both States and the Federal government to improve their policies. While our report has the methodological limitations inherent in all non-experimental studies, and many critical questions remain unanswered, we have learned far more about current State efforts than was previously available.

Not all solutions to the problems of teen pregnancy and parenting will or should involve the Federal government, or any government. It is obvious, however, that most States do not believe current efforts -- public or private -- are adequately funded or coordinated.

We hope that this report will help all levels of government, as well as private and church-supported organizations, to find better ways to prevent pregnancies among at-risk teens, and to craft more adequate policies and services to address the needs of pregnant and parenting teens and their children.

Failure to act now on what we know, and to pursue solutions which may still elude us, are a *de facto* acceptance of more private pain and more public cost.

FINDINGS

HIGH COSTS TO TEENS, THEIR CHILDREN, AND GOVERNMENT

HEALTH INDICATORS REMAIN POOR

Low birthweight and infant mortality rates for infants born to adolescents remain significantly higher than for other infants. In addition, for fifteen of twenty States able to report on first trimester prenatal care for teens, the percent receiving such care declined between 1980-82.

TEEN PREGNANCY COSTS BILLIONS

Data from States which have calculated the amount of public funds expended for pregnant teens, teen parents, and their children suggest that several billion dollars are spent each year for such purposes. Most State calculations included the cost for one or more of several programs, including: AFDC, Medicaid, Food Stamps, WIC, and neonatal care.

INADEQUATE INFORMATION

STATES UNABLE TO DOCUMENT EXTENT OF TEEN PREGNANCY OR THEIR RESPONSE

Beyond collecting information on the number of births to teens, States are unable to answer most basic questions related to teenagers at risk, pregnant, or parenting teens, including: where they are being served, what benefits they are receiving, who finishes high school and who finds employment.

LITTLE KNOWN ABOUT FEDERAL EFFORTS

Fewer than one-half of the States can determine the number of adolescents served, the type of service provided, or the amount of funds spent for five major federal programs which can be used to address teenage pregnancy and parenting. These are: maternal and child health, family planning, adolescent family life, Medicaid and job training.

SIGNIFICANT BARRIERS REMAIN

PREVENTION EFFORTS OVERLOOKED

Prevention programs, including family life education, pre-adolescent and adolescent education, health education, sex education, contraceptive information and services, abstinence education, as well as educational programs for the parents of high risk-teens, receive much less emphasis than programs for already pregnant and parenting teens.

COMPREHENSIVE SERVICES LACKING

While those States with initiatives are moving toward more comprehensive services, there is still little indication that most States are taking a comprehensive approach to addressing the issue of teen pregnancy and parenting.

INSUFFICIENT EDUCATION FOR TEENS AND COMMUNITIES, POOR COORDINATION, INADEQUATE FUNDING, AND INSUFFICIENT DATA MOST SERIOUS BARRIERS TO IMPROVED SERVICES

Although a variety of strategies are required to prevent adolescent pregnancy and address the needs of pregnant and parenting teens and their children, States cite lack of education and public awareness, and the lack of coordination among existing services as the most serious barriers to providing improved and comprehensive services and information for teens.

Other barriers frequently cited include inadequate funding and insufficient data necessary to target populations or determine who is receiving related services.

FEW EFFORTS TO INVOLVE TEEN FATHERS

State efforts to include adolescent males and fathers more effectively in prevention and intervention programs remain very limited. State actions to strengthen child support and paternity laws have also moved very slowly.

SOME PROMISING TRENDS

MORE STATES FOCUSING ON TEEN PREGNANCY

In the last five years, there has been a modest increase in statewide initiatives which address teen pregnancy and parenting. Seven of these States appear to have funded, or plan to fund, new, more extensive and/or comprehensive services. Twenty-three States report having either a special task force or an initiative related to pregnancy and parenting among youth.

PARENTAL INVOLVEMENT INCREASING

Efforts to expand the role of parents in teen pregnancy prevention are increasing. States report recent policy changes in schools, health clinics, and service agencies which are designed to increase parental involvement.

ADDITIONAL VIEWS OF HON. GEORGE MILLER, CHAIRMAN; HON. WILLIAM LEHMAN; HON. PATRICIA SCHROEDER; HON. MATTHEW F. McHUGH; HON. TED WEISS; HON. BERYL ANTHONY, JR.; HON. BARBARA BOXER; HON. SANDER M. LEVIN; HON. BRUCE A. MORRISON; HON. J. ROY ROWLAND; HON. GERRY SIKORSKI; HON. ALAN WHEAT; HON. MATTHEW G. MARTINEZ; HON. LANE EVANS; HON. HAMILTON FISH, JR.; AND HON. NANCY L. JOHNSON

We find unacceptable a million, mostly unwanted, teen pregnancies each year; 500,000 births, more than half to unmarried teens; and, 400,000 abortions.

Not only is it unacceptable, but as this Committee has heard, it is devastating for the vast majority of the teen parents. They will earn less, they will complete fewer years of education, their infants will be at risk, and their early marriages will be more likely to end in divorce.

Such devastation is not necessary. Other countries do much better. And there are currently examples throughout this country of programs that can reduce both the incidence of unwanted pregnancy, and the ensuing consequences. So we know that the private pain and public cost of teen pregnancy need not be inevitable.

The choice is now up to policymakers, at every level. We can expand opportunities for adolescents to participate more fully in society, including the opportunity to gain better control over their own lives by having the necessary information and services to make responsible choices about parenting. And we can give parents of these adolescents the help they are seeking.

Or we can continue to condemn and ignore this national tragedy, allowing it to take its toll on young people and the nation.

This is not to suggest that it is easy to deal with the problems of adolescence, especially those involving sexual activity. As we were told at one of our early hearings:

> Because we give adolescents almost no opportunities for acknowledged competence beyond academics and athletics, and because we fail to invite the contributions they are ready to make to their communities, many adolescents are barred from adult recognition. In so doing, we abandon them to the peer group which, while more often than not supportive and generous, is equally shaky and needy (15).

It is within this often confused, and relatively immature context, that the problem of teen pregnancy must be understood. For many of the teens involved, poverty is also a daily fact of life, and is a further constraint on their opportunities.

That is why we feel so strongly about reaching young people with adequate prevention and intervention efforts. They need, by their age and circumstance, our best and most honest guidance regarding questions of sexual behavior, pregnancy and parenthood.

We believe we can do better by focusing much more on preventing unwanted teen pregnancies. Those who are concerned about the issue of adolescent pregnancy and parenthood agree that preventing teenage pregnancy is a priority.

We know contraception works. We know sex education can make a real contribution. We know comprehensive health care is essential. And we know there are emerging prevention models, like school-based clinics, that have already shown enormous potential.

This Report makes all too clear that these proven and promising preventive approaches are everywhere too few, under-emphasized, and uncoordinated.

We can be certain what will happen if we continue along this path.

We will see hundreds of thousands more teen parents each year, looking at a future of almost certain poverty.

We will see their infants, from the outset, at much greater risk of mortality and morbidity. We will watch these families struggle to overcome great odds. We will see their children perform less well than others in school, increasing the likelihood that they too will drop out of school, beginning a repeat of the same high-risk cycle.

In addition to the private tragedy of teen pregnancy, this Report confirms the astounding costs of teen pregnancy. Literally tens-of-billions of public and private dollars are spent each year caring for the basic needs of these infants, and their parents.

PERSISTENCE AND MAGNITUDE OF TEEN PREGNANCY CAUSES PARENTS TO SEEK HELP

During the 1970s, millions more teenagers became sexually active, and at younger ages. In the 1980s, this increase has slowed and may even be reversing (9). The pregnancy rate among teens has followed a similar pattern -- with an increase in the 1970s, and considerable slowing of the increase since 1980 (5).

We are heartened that these trends may be turning around.

But the fact remains that too many teenagers become pregnant or bear children when they are not ready or able to shoulder the emotional, physical, or fiscal responsibilities of being parents. In 1982 (the most recent year for which comparable information is available), 1,110,287 young women through age 19 became pregnant, and 523,531 gave birth (1). Of those who gave birth, 51% were unmarried (8).

These persistent trends have greatly affected public attitudes regarding adolescent behavior and parents' roles.

As evidenced in a recent Lou Harris poll, many more parents are now talking with their children about sex, but the topic of birth control is not often included in those conversations.

Parents admit they need help now, and overwhelmingly support sex education in schools. They believe eliminating such education would lead to more teen pregnancies. Also, a two-to-one majority of adults favor public schools linking up with family planning clinics, so that teens can learn about contraceptives and obtain them (10).

CONTRACEPTION IS EFFECTIVE PREVENTION

While contraception alone cannot solve the problem of teenage pregnancy, contraception has had a significant impact on averting unwanted pregnancies and births.

According to one study, absent the use of contraceptives, in 1976 there would have been 680,000 additional pregnancies among unmarried sexually active 15-19 year olds. A separate analysis showed that enrollment by teens in family planning clinics averted 119,000 births and an estimated 331,000 pregnancies in 1976. Combining these two findings, it appears that family planning programs were responsible for half of the averted unintended pregnancies in 1976 (14).

We also know that, contrary to what many believe, teens can be effective contraceptive users. In other countries where the rate of sexual activity is as high as in the United States, the teen pregnancy rate is significantly lower. In the Netherlands, Sweden, France, Canada, and England and Wales, contraceptive services and sex education are more readily available and teens use contraceptives consistently and effectively (6). Even in the United States in 1982, teenagers aged 15-19 had the highest annual visitation rate to all sources of family planning services (private, clinics, and counselors) than all other age groups (9).

The evidence shows plainly, though, that teens are likely to become pregnant during the first six months of sexual activity -- the time period when they are delaying contraceptive use. The fact is that too many teens do not use a contraceptive at first intercourse (more than 75% of teens under age 15; 59% of 15-17 year olds; and 45% of 18-19 year olds), and delay seeking contraception for six months to two years, depending on their age. (2).

Studies have found that teenagers delay seeking contraception for the following reasons: 1) belief that time of month was low risk; 2) their youth; 3) infrequent sex; 4) general belief they could not get pregnant; 5) and difficulty in obtaining contraceptives (2).

Thus, while contraception can be effective, it is too frequently unavailable or unused when sexual activity begins.

SEX EDUCATION CAN HELP REDUCE TEEN PREGNANCY

We realize that sex education remains a controversial topic. Many have questioned whether schools are a proper place for sex education. Others have questioned the effectiveness of such efforts in influencing rates of sexual activity, contraceptive use, and pregnancy and birth rates.

We believe, however, that many types of sex education can contribute to reducing teen pregnancy. Studies show that sex education leads neither to higher levels of teenage pregnancy nor to greater sexual activity (7). In fact, a 1982 study found that teenagers who received sex education were more likely to use some method of birth control. One study combining data from 1976 and 1979 found a lower pregnancy rate among females who had received sexuality education than among those who had not (7).

Another recent study, which examined the association between sex education and adolescent sexual behavior, showed that 15-16 year old adolescents who had taken a course in sex education were less likely to be sexually experienced. This study also showed that parental roles are supplemented, not undermined, by sex education programs (4).

MORE FAMILY PLANNING SOUGHT BY STATES

The family planning program is the major source of prevention services to adolescents. An estimated 34% of those served are women under the age of 20.

Although controversial to some, according to our survey, states view family planning as very effective. Several states noted that this program assists in the provision of services to teens and encourages greater family involvement. Ten states recommended increasing the availability and accessibility of family planning services.

SCHOOL-BASED EDUCATION/CLINIC SERVICES ARE EVEN MORE EFFECTIVE

Recent research, using more sophisticated methodology, has also shown that when education is combined with clinic services at an accessible location, teen pregnancy is reduced.

In this research study, nine different prevention programs were evaluated and compared for relative effectiveness 1/. While most programs increased knowledge among teens, no program significantly increased or decreased rates of sexual intercourse. None of the non-clinic programs had a significant impact upon reported use ofdifferent methods of birth control. Only the education/clinic approach increased the use of birth control and substantially reduced the number of births. It also increased the proportion of pregnant adolescents who remained in school, and decreased the number of repeat pregnancies among them (7).

This study was based upon the comprehensive high school-based-clinic program in St. Paul, Minnesota, which the Select Committee visited in 1983, and corroborates the earlier information given to the Committee showing a 56% reduction in the fertility rate. Since our visit the program has been expanded and has shown consistent results.

Another particularly noteworthy education/clinic program begun in 1981 in two Baltimore schools reduced pregnancy rates among sexually active adolescent females, while overall teenage pregnancy rates in Baltimore were on the rise. Services provided included sexuality edcuation, counseling, and referral for contraceptives (11).

Mounting evidence suggests that low self-esteem and poor prospects for the future, including too few academic or employment opportunities, may contribute to a teenager's decision to have a child (3, 12, 13).

1/Programs selected: 1) A comprehensive, semester-long course for juniors and seniors; 2) A one-year course for juniors and a semester seminar for seniors; 3) A one-year freshman course and a semester course and a semester-long junior/senior seminar; 4) An integrated K-12 program; 5) A five session course in schools, including a parent/child program; 6) A six-session course in schools, including a peer education program; 7)A 10-16 session course for youth groups; 8) An all-day conference; 9) A high school education/clinic program.

School-based clinics, by providing a range of services to adolescents, can detect other health, academic, social and family problems that may contribute to low self-esteem and lowered prospects for future self-sufficiency. For example, during the first three months of operation, seventy-five percent of the visits to DuSable High Schools's clinic were unrelated to family planning. They revealed previously undetected health and emotional problems that were amenable to treatment (17). Similar information has emerged from clinics in Dallas, Kansas City and St. Paul.

In St. Paul, more than 60% of the clinic visits were for services unrelated to family planning or pregnancy, including child abuse, mental health problems, financial problems, and weight control. Treatment of minor and acute illness, and preventive health care accounted for more than one-third of all the visits (16).

Part of the success of comprehensive school based clinics is due to their broad base of support in the community. Each program draws together parents and students, schools and health agencies, churches and social service providers, and governmental and private resources. And each program organizes its services to fit the environment, facilities, and concerns of the teenagers it is designed to serve.

Fifteen States in our survey reported programs providing school-based health services. Seven States already have or are planning to start school-based health clinic programs that offer health services to the entire student population.

Following are just two examples of States' recommendations on this approach:

Connecticut

School-based health clinics are a demonstrated means of providing comprehensive medical, educational, and counseling services. These clinics provide total medical services to students, not just services related to the prevention of pregnancies and pre- and postnatal care. In terms of the adolescent pregnancy problem, the goals of such clinics are the prevention of adolescent pregnancies, reduction of second pregnancies, reduction of obstetrical complications, and improvement of the health of the infant and mother.

In Connecticut, three clinics similar to the St. Paul model are now operating, although not on a full-time basis. They are located in New Haven, Bridgeport and Hartford. The task force recommends expanding these programs from half-time to full-time operations. It also recommends that the state, through the Department of Health Services, provide two planning and development grants for the establishment of one new urban school clinic and one new rural school clinic.

Maryland

The Governor "direct the Department of Health and Mental Hygiene and the Maryland State Board of Education to develop a joint plan for a network of comprehensive school-based health programs and that the Governor include funding for such programs in high-risk areas in

58-957 O - 86 - 4

the Fiscal Year 1987 budget. The plan should include a profile by which those middle and senior high schools with significant teen pregnancy problems could be identified and placed in priority order."

OTHER COMPREHENSIVE SERVICES ALSO REDUCE TEEN BIRTH RATES

At earlier Select Committee hearings and site visits, we have seen other prevention strategies which have reduced teen birth rates. For example:

- The Young Adult Clinic at the Columbia Presbyterian Medical Center in Washington Heights, New York, offers: health services and contraceptive counseling to adolescent 21 and younger; outreach to schools and community organizations to reach pre-teens before they bbbecome sexually active; parent sex education seminars and conferences; a bilingual improvisational theater troupe to increase parent-teen communication; and a community health advocate program staffed by community residents.

  These efforts decreased the percent of teens who were pregnant before their first clinic visit from 44% to 34%, and decreased the percentage of births to teens in that community from 13.8% in 1976 to 11.9% in 1983.

- The Teen Health Project at the Ryan Community Health Center in New York City provides: routine health care and health maintenance, immunizations, job and sports physicals, complete contraceptive care, education and counseling, WIC and social service referrals, outreach to schools and youth programs, and referrals to job development and substance abuse programs.

  As a result, since 1976, the rate of teen pregnancies in their community has declined 13.5%.

SOME STATES BEGIN TO EMPHASIZE PREVENTION

Effective prevention includes a variety of approaches. Sex education, family life education, abstinence education, family planning, teen counseling services, general health services for adolescents, school dropout prevention programs, parent education programs, and mass media campaigns are all accepted and important preventive measures.

Eleven States specified that there has been too little focus on prevention (Georgia, Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, North Dakota, Texas, Washington, and Wyoming). Many others also called for increasing services for adolescents before a first pregnancy occurs.

Illinois has made a major commitment to adolescent pregnancy prevention, and appropriated $12 million for its model statewide initiative, "Parents Too Soon", begun in 1983.

As part of its statewide initiative, the New York Governor's Task Force on Adolescent Pregnancy pointed out the inadequate focus on prevention which has historically characterized service delivery to teens.

North Carolina acknowledged the same problem, noting "too little is being provided too late for primary prevention."

CONCLUSION

It is not enough to lament the problem of unwanted teen pregnancy and parenting, or to chastise its victims.

Everyone regrets the number of unwanted pregnancies and births to teens, the abortions, and the lack of services to those who become teen parents and their infants.

Everyone agrees that, for the majority of these teens and their children, life will be much more difficult than it is for others.

What is important is to start building on the base of knowledge that we have about our teenage population, and on the information we have about coping with a wide range of problems that affect teens in America.

This effort must begin by seriously dealing with what may be the single most devastating event in a young adolescent's life -- an unwanted teenage pregnancy.

To take seriously our responsibilities as parents, providers and policymakers, we have an obligation to provide better, more consistent, and more honest guidance and opportunities for teens than we have.

We believe that this Report provides more than enough evidence to suggest that very great progress can be made. Some states and communities have begun to take up the challenge. The state and local innovations identified in this report should serve as models in this important effort.

They cannot do it alone. Without a greater effort on our part, the crisis-oriented, uncoordinated, and piecemeal efforts which states have described to us as totally inadequate, will continue.

It is our hope that this Report will galvanize a more concentrated commitment to America's adolescents from both public and private talent and resources.

George Miller, Chairman
William Lehman
Patricia Schroeder
Matthew F. McHugh
Ted Weiss
Beryl Anthony, Jr.
Barbara Boxer
Sander M. Levin
Bruce A. Morrison
J. Roy Rowland
Gerry Sikorski
Alan Wheat
Matthew G. Martinez
Lane Evans

Hamilton Fish, Jr.
Nancy L. Johnson

REFERENCES

1. Alan Guttmacher Institute, Unpublished data, 1985.

2. Baldwin, Wendy, "Trends in Adolescent Contraception, Pregnancy and Child-bearing," Premature Adolescent Pregnancy and Parenthood. Submitted to Select Committee on Children, Youth, and Families hearing, "Teen Parents and Their Children: Issues and Programs, July 20, 1983.

3. Children's Defense Fund, "Preventing Children Having Children," Clearinghouse Paper No. 1, 1985.

4. Furstenburg, Frank F., et al., "Sex Education and Sexual Experience among Adolescents," American Journal of Public Health, Vol. 75(11), p. 1331, November, 1985.

5. Hofferth, Sandra, Demographic and Behavioral Science Branch, Center for Population Research, NICHD, DHHS, Personal Communication, December 4, 1985.

6. Jones, Elise, et al, "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications," Family Planning Perspectives, Vol. 17(2), p. 52, March/April 1985.

7. Kirby, Douglas, "Sexuality Education: An Evaluation of Programs and Their Effects, An Executive Summary," Network Publications, Santa Cruz, 1984.

8. National Center for Health Statistics, 1983.

9. Pratt, William, et al., "Understanding U.S. Fertility: Findings From the National Survey of Family Growth, Cycle III," Population Bulletin, Vol. 39(5), December, 1984.

10. "Public Attitudes About Sex Education, Family Planning, and Abortion in the United States," Poll conducted by Louis Harris and Associates for Planned Parenthood Federation of America, August-September 1985.

11. "Researchers Say Counseling Reduced Teen Pregnancies," Article on a presentation by Laurie Zabin to the American Public Health Association, Boston Globe, November 21, 1985.

12. Select Committee on Children, Youth, and Families, "Children, Youth, and Families: 1983, A Year End Report," March 1, 1984.

13. Select Committee on Children, Youth, and Families, Testimony of Elizabeth A. McGee, Director, Economic Self-Sufficiency for Teenage Parents Project, National Child Labor Committee, at the hearing entitled, "Teen Parents and Their Children: Issues and Programs," July 20, 1983.

14. Select Committee on Children, Youth, and Families, Testimony of Wendy Baldwin, Chief, Demographic and Behavioral Sciences, Center for Population Research, National Institute of Child Health and Human Development, at the hearing entitled, "Teen Parents and Their Children: Issues and Programs, July 20, 1983.

15. Select Committee on Children, Youth, and Families, Testimony of Joan Lipsitz, Director, Center for Early Adolescence, University of North Carolina, Chapel Hill, at a hearing entitled, "Teenagers in Crisis: Issues and Programs," October 27, 1983.

16. St. Paul Maternal and Child Health Program, Annual Report, January-December 1984.

17. The Ounce of Prevention Fund, Chicago, Mimeo Report, Fall 1985.

ADDITIONAL VIEWS OF HON. NANCY L. JOHNSON AND HON. HAMILTON FISH, JR.

Preventing adolescent pregnancy is an issue which is central to any comprehensive federal policy to assist American families, American women, and an indeterminate number of future generations. It is an issue that is clearly within the purview of the Select Committee on Children, Youth, and Families to provide leadership, and we are pleased that the Committee has begun to address this serious problem.

For women, who have made great strides in the past two decades in expanding their horizons to include a range of abilities, the implications of teen pregnancy are devastating. Only half of the girls who became mothers before their 18th birthday received their high school diplomas; 70% of women on the public assistance rolls did not complete their high school education; and, an equal percentage of welfare recipients under 30 had their first child as a teenager.

These numbers make a mockery of efforts to address the feminization of poverty. Strategies which have only recently begun to direct girls into higher-paying, nontraditional fields will be lost on a generation of mothers who, lacking an education, may become dependent on public assistance for long periods of time. Far too many young women are narrowing their options in their teen years.

Particularly disheartening, and noteworthy as indicating the urgency of the problem, are the health risks of pregnancy to young mothers and children. Poor nutrition and inadequate medical attention, conditions which too often characterize these pregnancies, in turn makes the risk of low birthweight and infant mortality significantly higher for the child of a teenage parent.

Teen pregnancy today even has negative implications for tomorrow's retirees. In 1950, the wages of 17 workers contributed to the benefits of each Social Security beneficiary. By the year 2000, the checks will reflect the contribution of only three workers. With this dramatic shift in the ratio of retirees to workers, we can't afford to ignore that the quality of life for future seniors depends to a great extent on the job readiness of today's children. How can we expect that either the mothers or their children will be equipped to shoulder this responsibility?

Existing programs, especially preventive strategies such as Title X of the Public Health Services Act and the Social Services Block Grant, both successful in assisting adolescents, are appropriately cited in this report, together with state assessments.

We are disappointed, however, that the report has been limited to a compilation of existing efforts and has not provided the thorough examination and guidance that should be the role of a Congressional Oversight Committee and is so urgently required for a problem of this magnitude.

We are concerned that countless hours of staff time and enormous amounts of paper have been directed, at taxpayers' expense, to a directory which duplicates information gathering in a number of governmental entities, including the National Association of State Legislators, the National Governor's Association, and our own State agencies, all of which have published similar documents.

We believe that the number of teenage pregnancies, one million and rising, and the rate of abortions, higher than any industrialized nation, demonstrate that these approaches are inadequate; they cry for an immediate and creative response, and we would like to see this report, not as the final statement on the problem, but as the first of several examinations of possible courses of action.

Finally, we are dismayed by the lack of participation in the study accorded to Committee Members. Members were allowed to comment on survey questions and pursuant to Committee rules, provided with an opportunity to express an opinion in the final three day comment period prior to the publication of this document. However, Members' individual views were not solicited when the decision was made to conduct a survey, a decision which had direct impact on the final outcome.

Despite the importance of the subject, and the best and most thorough efforts of the Select Committee's staff, we cannot, in good conscience, appear to be wholeheartedly behind this report. In our view the report does not reflect the work of Committee Members from beginning to end, nor does it seek to determine the root causes, the consequences, and possible new solutions to this critical problem of such individual and collective importance.

Squarely facing the challenge presented by an overabundance of adolescent pregnancies is crucial to creating the opportunity this nation has always symbolized and to preserving the quality of life for current and future generations. As Members of the Select Committee for Children, Youth, and Families we wish to express our concern and commitment to solutions for this problem, and our expectation that future efforts will more clearly identify causes and stimulate the spectrum of new aproaches that must be found if our policies are to make a difference.

Nancy L. Johnson
Hamilton Fish, Jr.

MINORITY VIEWS OF HON. DAN COATS, RANKING MINORITY MEMBER; HON. THOMAS J. BLILEY, JR.; HON. DAN BURTON; HON. BARBARA F. VUCANOVICH; HON. DAVID S. MONSON; AND HON. ROBERT C. SMITH

INTRODUCTION

We are very pleased that the Select Committee is focusing its attention on adolescent pregnancy. The increasing incidence of pregnancies among young, unmarried teens is one of the most difficult and far-reaching social problems our nation faces. It is a major factor affecting increases in poverty, unemployment, infant mortality, abortion, child abuse, juvenile delinquency and a host of other tragic ills of our day.

This report will be useful to those working at all levels to address the causes and consequences of teen pregnancy. Especially useful are the State Fact Sheets, the heart of this report. From these Fact Sheets, we can learn of the variety of programs and initiatives springing up in our 50 States. States have much to learn from each other and will prove each others' best teachers. We hope that this report will prove a valuable resource through which successful programs can be discovered and duplicated, and mistakes avoided.

However, much as we are pleased with the strengths of the report and the genuine cooperative spirit shown by the Majority during its development and writing, there exist fundamental disagreements which prevent us from giving the report our endorsement. These involve matters which were discussed when the survey was first drawn up and throughout the process of revising the report as first drafted by the Majority.

The most important part of this issue is the prevention of pregnancies among unmarried teens. Without minimizing the importance of appropriate services to pregnant and parenting teens, we still must recognize that an effective means of prevention would be preferred by all. No government effort, no matter how well-designed and well-funded, will compensate children for their absent fathers.

A strong case can be made that pregnancy prevention policies we have pursued so far have been ineffective. Births to teens have been reduced through abortion. Pregnancies to all teens have declined slightly in recent years. But pregnancies to unmarried teens have risen higher than we would have thought possible 15 years ago.

The design of this report does not lend itself to treatment of this most important issue. Discussion of prevention programs centers on availability, access, and funding, but never touches upon the prior question of effectiveness. There is little point in discussing how to increase the availability of prevention programs when we don't even know if those programs work.

We very much appreciate the hard work of the Select Committee staff and the Majority's sincere efforts to address our concerns in this report. But just as the Majority has found itself unable to bend on certain points which it considers fundamental to understanding this problem, so have we. Adolescent pregnancy is a matter which is important enough to deserve continued and open-minded debate. We hope that this report signals the beginning of that debate, and not the end.

I. DEFINING THE PROBLEM

The Select Committee report suffers from a lack of clear definition of the problem of teen pregnancy. This is due in part to the difficulty of obtaining some data, but in part also to a fundamental disagreement among Committee Members as to what the real problem is. In any case, this lack of definition manifests itself in a general failure to distinguish between married and unmarried teens and in a far greater emphasis on birth rates than on pregnancy rates.

We believe that the general public does indeed distinguish between the married and the unmarried in its concern for teen pregnancy. Nor is it concerned only with births to unmarried teens, but with pregnancies as well. Family planning providers are certainly sensitive to this latter difference; few would claim success if they lowered the numbers of births simply by increasing the numbers of abortions.

Pregnancies among unmarried teens--what the trends are and how to prevent them--this is the public's concern. This is our concern. But information on pregnancies to unmarried teens is difficult to obtain. Pregnancy figures generally are calculated by adding the figures for births, abortions, and miscarriages. Problems arise in attempting to distinguish between pregnancies to married and unmarried women. Birth certificates give the marital status of the mother, but abortion information does not. Therefore, surveys which must rely upon self-reporting are a major source for pregnancy estimates. But self-reporting of abortions is usually thought to be low. And it is more likely that abortions performed before 1973 are underreported.

Recognizing these difficulties, the fact remains that the information which is most difficult to obtain is also that which would best answer our questions. If we want to learn about pregnancy rates for unmarried teens, data which does not distinguish between the married and unmarried can only bring us so far. Therefore, realizing that survey results give us estimates rather than statistics, we must move forward with what we have if we are to address the most critical concerns.

Teen Pregnancy Outcomes

Of all pregnancies to teens aged 15-19, slightly less than half result in live births, about 40% are aborted, and the remainder are lost through miscarriage. Of live births, about half are born to married teens, and a little more that half of those were conceived after marriage. (See Table 1.)

Differences Between Older and Younger Teens

In 1981, about 60% of all pregnancies to teens were to 18 and 19 year olds. The pregnancy rate for 18-19 year olds was about 225% greater than the rate for those 15-17, but the birth rate was about 255% greater. (See Table 2.) Older teens are less likely than younger teens to have pregnancies ended through abortion or miscarriage.

Mothers 18-19 have a lower percent of low-birth-weight babies than do those 15-17. (See Figure 3 of Committee Report.) Mothers 18-19 are also more likely to be married than those 15-17.

Differences Between Married and Unmarried Teens

Married teens tend to have healthier babies than unmarried teens. In fact, married 15-17 year olds have lower rates of low-birth-weight babies than unmarried women of any age. (See Figure 3 of Committee Report.) About half as many unmarried teens begin prenatal care in the first trimester of pregnancy than do those teens whose pregnancy was conceived after marriage. Of those who become pregnant outside of marriage, almost 80% more of those who marry before the birth begin early prenatal care than do those who remain unmarried. (See Table 3.)

Teens who are married at the birth of their babies have fewer low-birth-weight babies. Among teen mothers who began prenatal care in their first trimester, differences between married and unmarried teens with regard to fetal losses, low-birth-weight, and low 1-minute Apgar scores are marked. Unmarried teens were found to have more than twice the percent of low-birth-weight babies as married teens, regardless of whether the married teens' pregnancies were premaritally or postmaritally conceived. (See Table 4.)

Pregnancy Rates for Unmarried Teens

Births to teens have declined over the past 15 years, but the decline is due almost entirely to the increase in abortions. (See Figure 1, Committee Report.) Pregnancies to unmarried teens have soared. Studies by Zelnik and Kantner in 1971, 1976, and 1979, and by the National Survey of Family Growth in 1982 measured the percentage of pregnancies for never-married women aged 15-19 in those years. The results showed a near doubling of pregnancies from 1971 to 1979 (from 8.5% to 16.2%) and then a slight drop (to 13.5%) in 1982. More interesting, however, are the percentage of pregnancies among sexually active teens during this eleven year period. These have remained nearly constant, rising from 28.1% in 1971 to 32.5% in 1979, and then falling back to 30.0% in 1982. (See Table 5.)

The significance of these last figures is great. If the pregnancy rates among unmarried sexually active teens have remained constant over the past several years, then the chief factor in the increase of pregnancies among unmarried teens is the increase in the percentage of those who are sexually active.

The major thrust of almost all teen pregnancy prevention programs has been to decrease the percentage of sexually active teens who become pregnant. Very little effort has been made to prevent teens from becoming sexually active. Now, after nearly a decade and a half of this policy, it seems that there has been no change in the percentage of sexually active teens who become pregnant, but there has been a huge increase in the percentage of teens who are sexually active. (See Table 6.) And this increase in sexual activity has led to a proportionate increase in pregnancies to unmarried teens.

II. EXAMINING SOLUTIONS

Efforts to increase use of contraceptives among sexually active teens seem to have been successful. According to studies by Zelnik and Kantner, use of oral contraceptives (as the method most recently used) by sexually active unmarried teens doubled from 1971 to 1976 (23.8% to 47.3%) and declined slightly (to 40.6%) in 1979. Yet as stated in the lead editorial of the October, 1980 issue of Family

Planning Perspectives, the dilemma persists that, "more teenagers are using contraceptives and using them more consistently than ever before. Yet the number and rate of premarital adolescent pregnancies continues to rise."

In recent years, various groups have come up with plans for addressing the problems of teen pregnancy anew. The solutions they have proposed seem to lead along two radically different paths. One leads back to the family and acknowledgement of parental responsibility while the other leads further from the family, towards schools as the provider of guidance.

Family Involvement

The "family path" led to the 1981 change in Title X which mandated increased efforts by Title X providers to involve parents in their children's decisions regarding sexual activity and contraceptive use. It was also responsible for the creation of the Adolescent Family Life Program, which emphasizes parental authority, family involvement, and the postponement of sexual activity for teens. Finally, it can be seen in various state and federal efforts to require parental consent or notification for minors receiving prescription contraceptives or abortions.

Responses to the Select Committee survey indicate that several states have taken the mandate for increased parental involvement to heart. They have initiated special programs for parents and teens in efforts to increase communication. In all, 13 states indicated that they had recently taken steps to encourage parental involvement in their programs.

Eight states indicated that they require parental notification or consent for minors to receive prescription contraceptives or abortions. Such requirements are generally supported by parents. In a September, 1985 survey conducted for Planned Parenthood Federation of America, 52% of parents with children aged 6-18 said that they favored "a federal law prohibiting family planning clinics from giving birth control assistance to teenagers unless they have received permission from their parents." Forty-four percent opposed such a law and 4% were not sure. Fifty-four percent of Blacks and 56% of Hispanics favored a parental consent law.

Family planning providers often criticize parental consent and notification requirements, contending that they will result in an increase in pregnancies and births to teens. However, a review of the data provided by those states reporting such requirements yielded no indication of significant increases in pregnancies, births, or abortions which might have resulted from the requirements. In Minnesota, a 1981 law requiring parental notification for abortions was followed by dramatic reductions in abortions, births, and pregnancies. From 1980 to 1983, abortions to teens aged 15-17 decreased 40%, births decreased 23.4%, and pregnancies decreased 32%. During this same period, the number of teens aged 15-19 decreased 13.5%. (See Minnesota State Fact Sheet.)

School-Based Programs

The other path to pregnancy prevention leads through the schools. Its strengths include comprehensiveness, confidentiality, and easy access. School based health clinics have received much publicity in recent months, largely because of the success of the oldest and best

known of these projects, in St. Paul, Minnesota, but also because of the protests of parents in some new school sites. Members of Congress have already introduced legislation for federal grants to start up new school-based projects.

The success of the St. Paul program seems remarkable from the statistics often quoted. Births to teens in the participating schools declined from 59 per thousand high school girls in 1976-77 school year to 21 per thousand in 1979-80, but then increased again to 37 per thousand in 1984-85. Because the program does not collect its data in the same way as does the city of St. Paul or the state of Minnesota, comparisons are difficult. But the greatest difficulty with the numbers from the St. Paul program is that they reflect <u>births</u> to teens, not pregnancies. Pregnancy rates for the schools are not available.

More interesting is the fact that the decline in births reversed itself during the same school year that Minnesota passed its law requiring parental notification for abortions. As was noted above, enactment of the law was followed by statewide decreases in pregnancies, births, and abortions among younger teens. But as these declined for the state as a whole, birthrates increased in the St. Paul school-based program.

School-based health clinics seem to lead in a direction quite opposite to that of family-oriented programs. Descriptions by those who promote the clinics call into question those qualities most touted as chief strengths.

"Comprehensiveness" serves a double purpose--

> Most school-based clinics began by offering comprehensive health care, then added family planning services later, at least partly in order to avoid local controversy. The early St. Paul experience demonstrated that a clinic limited to providing family planning services, pregnancy testing, prenatal and post-partum care, and testing and treatment for STDs (sexually transmitted diseases) will be unacceptable even to many of the students who want these services.
>
> "School-Based Health Clinics: A New Approach To Preventing Adolescent Pregnancy?"
> Joy Dryfoos
> <u>Family Planning Perspectives</u>, Vol. 17, No. 2, March/April 1985. p. 71.

> High rates of childbearing among students often are cited as the rationale for initiating on-site health clinics, yet school-based clinics generally are presented as comprehensive, multi-service units that emphasize physical examinations and treatment of minor illnesses. This portrait certainly is valid, considering that only a small proportion of all clinic visits are for family planning. Nevertheless, in most clinics new patients (whether male or female) are asked at their

initial visit if they are sexually active. If they are or plan to be soon, they are encouraged to practice contraception.

"School Based Health Clinics," p. 72.

"Confidentiality" takes on the color of sneaking--

Clinic personnel stress the importance of maintaining confidentiality. One difficulty is that while students' privacy must be respected, it is also important to gain the acceptance of parents, so that parents will permit their children to be treated in the school clinic. School-based clinics generally require parental consent before they will provide medical services to teenagers. In some clinics, parents are asked to sign a blanket consent form unrelated to any specific clinic visit. In others, the form lists each service, including family planning, and a student may receive only the services that have been checked. Most consent procedures apply for the entire period of the student's enrollment.

"School-Based Health Clinics," p. 73.

The relative effectiveness of the school-based clinics is clearly related to the ease with which the young people can be followed up without endangering the confidentiality of the relationship. (That is, it is often difficult to follow adolescent clinic patients who have not informed their parents about their participation; but in the school program, the young people can be reached without communications to the home.)

"Adolescent Pregnancy Prevention Services In High School Clinics"
Laura E. Edwards, Mary E. Steiman, Kathleen A. Arnold and Erick Y. Hakanson.
Family Planning Perspectives, Vol.12, No. 1, January/February 1980, p. 12.

"Easy access" seems to refer more to the clinician's access to the child than the child's access to the clinician--

Almost all follow-up can be undertaken in school clinics, as family planning patients can be contacted easily in their classes and scheduled for follow-up visits. Confidentiality still can be maintained, because classmates do not know why the student is being asked to come to the clinic. Nevertheless, follow-up is perceived as a major challenge; one administrator hopes to reward students who make regular return visits with points toward school trips or other perquisites. In another program, students who miss a monthly

follow-up visit receive a telephone call at home from the school nurse, requesting simply that they return to the clinic for a checkup.

"School-Based Health Clinics," p. 73.

School-based programs help to link health education and clinic services. Clinic staff often conduct sex education and family life classes in the school, so they have ample opportunity to encourage the students in the classroom to attend the clinic. One school has a room designated for health education, where contraceptives such as diaphragms and condoms are displayed; there are also counseling offices where students can talk to health educators in private. In that school, all sexually active students receive counseling, including a psychosocial evaluation.

"School-Based Health Clinics," p. 73.

Additionally, the nurse clinician keeps a log of all students on contraception and contacts them at least once a month in the school to discuss any problems related to contraceptive use. Some students have literally been seen on almost a daily basis, dropping by between classes, for example, to report to the nurse clinician, "I took my pill today, Mary."

"Establishing an Experimental Ob-Gyn Clinic In A High School"
Laura E. Edwards, Mary E. Steinman, and Erick Y. Hakanson
American Public Health Association, Washington, D.C., November 2, 1977, p. 3.

And the creative mix of public and private funding does not seem destined to last--

Although private funds have played an important part in starting up these programs, almost all of the school programs look to public support for continuation.

"School-Based Health Clinics," p. 73.

Although it is not fashionable to suggest that long-term viability depends on federal funding, it is difficult to imagine that foundations will be willing to support these programs permanently, except for special studies.

"School Based Health Clinics," p. 73.

It should be noted, too, that the "comprehensiveness" of the school-based clinic often precludes a separate consent form for children whose parents do not wish contraceptives to be made available to them. If a parent wishes his child to receive the same free medical services that all other children receive at the clinic (emergency treatment, routine school and sports physical exams, immunizations, examination, diagnosis and treatment of complaints, etc.) the parent must sign a form which also includes family planning, treatment of sexually transmitted diseases, and professional counseling regarding sexuality. (See Exhibit A.)

Will "Family Planning" Work for Young, Single Teens?

Currently, federal policy mandates that children be given contraceptives without their parents knowledge and consent. The result has been a dramatic increase in the rate of pregnancy among unmarried teens, due to a proportionate increase in sexual activity among unmarried teens and no decrease in pregnancy rates for those who are sexually active.

Rather than acknowledge the failure of current efforts, some now offer a few adjustments to the unsuccessful programs:

1) Ensure better access--(If teens will not come to the clinics, take the clinics to them.)

2) Increase confidentiality--(Parents, it seems, are still the greatest hurdle to teaching children "responsible sex".)

3) Offer free comprehensive health care which includes contraceptive services--(Make parents an offer they can't refuse.)

Will the school-based approach work? Those who also predicted the success of Title X services to teens say that it will. But the real answer depends on whether contraception is or can be the final solution to teen pregnancy. The contraceptive failure rate for teens who always use contraception is about 10% (Zelnick and Kantner, 1976 and 1979). This is not much different from the out-of-wedlock teen pregnancy rate for the population as a whole. Therefore, hypothetically, if sexual activity among teens reached 100% and the constant use of contraceptives reached 100%, we would still have a pregnancy rate of about 10%.

CONCLUSION

The task we face today is not a new one. Every generation has inherited the difficult job of bringing children into adulthood, and the same problems have presented themselves.

What is so different now? Why does the problem seem so much more difficult in this generation? Are babies born today different from babies born fifty years ago? Or is the difference in the adults who are raising them?

Have we really failed in our efforts to prevent pregnancies to unmarried teens? Or is it truer to say that we have abandoned them? Teaching our children to be adults is perhaps the most difficult job we have. Teaching them self-control, respect for themselves and others, fidelity, courage, and patience requires constant and tireless efforts. It also requires good example.

Progressively over the past 25 years we have, as a nation, decided that it is easier to give children pills than to teach them respect for sex and marriage. Today we are seeing the results of that decision not only in increased pregnancy rates but in increased rates of drug abuse, venereal disease, suicide, and other forms of self-destructive behavior.

Our excuse for this decision is, "The kids are going to do it anyway; we ought at least to protect them from the worst consequences of their behavior." But this is perhaps the weakest argument of all.

It is true that without adult guidance in matters of sexuality, adolescents will tend toward promiscuity. Evidence of this can be found in the near doubling in the percentage of sexually active teens in the years since we have replaced real guidance with medical technology.

But even today it is clear that teen sex is not inevitable. About half of all 18-year old females have never had premarital intercourse. (See Table 6.) Of those unmarried teenage girls who were labeled "sexually active", almost one in seven had engaged in intercourse only once (Table 7), and about 40% had not had intercourse in the last month (Table 8). These are not the marks of an irreversible trend.

The time has come to stop blaming the problem of teen pregnancy on the incorrigibility of our children or the ills of society. Our children have only us for guidance, and we are responsible for the condition of our society.

The real path back to a sane and effective policy to prevent teen pregnancies is not an easy one, but it is the only one that will work. It is also the only one that most of us would choose for our own sons and daughters. This path does not circumvent the family, but leads straight to the heart of it. It encourages communication between parents and children and is built on the firm foundation of parents' values, beliefs, and ambitions for their children.

This Committee is uniquely priviledged to have the time and resources to examine the broad question of what form this new direction in teen pregnancy prevention might take. It is our sincere hope that the Committee will take up this challenge and begin the work of rebuilding our confidence in our families and our children.

Dan Coats, Ranking Minority Member
Thomas J. Bliley, Jr.
Dan Burton
Barbara F. Vucanovich
David S. Monson
Robert C. Smith

TABLE 1

Estimated Distribution of Pregnancies to Teens in 1982 by Outcome

OUTCOME	NUMBER	PERCENT
Total Pregnancies to teens 15-19	1,092,645	100.0
Abortions	432,850	39.6
Miscarriages	146,037	13.4
Live Births	513,758	47.0
Conceived Postmaritally	145,907	13.4
Conceived Premaritally, Born Postmaritally	118,678	10.9
Born Premaritally	249,173	22.8

Source: Table 1; O'Connell & Rogers, 1984, Table 1.

TABLE 2

Estimated Number of Pregnancies and Pregnancy Rates by Outcome of Pregnancy, Age of Woman, and Race: United States, 1976, 1978, and 1981

AGE OF WOMEN	1976 ALL PREGNANCIES	1976 LIVE BIRTHS	1976 INDUCED ABORTIONS	1976 FETAL DEATHS	1978 ALL PREGNANCIES	1978 LIVE BIRTHS	1978 INDUCED ABORTIONS	1978 FETAL DEATHS
	NUMBERS IN THOUSANDS							
Under 15 Yrs.	32	12	16	4	29	11	15	4
15-19 Years	1,073	559	363	151	1,109	543	419	147
15-17 Years	NA	NA	NA	NA	438	203	169	66
18-19 Years	NA	NA	NA	NA	671	341	250	81

AGE OF WOMEN	1981 ALL PREGNANCIES	1981 LIVE BIRTHS	1981 INDUCED ABORTIONS	1981 FETAL DEATHS
	NUMBERS IN THOUSANDS			
Under 15 Yrs.	28	10	15	3
15-19 Years	1,103	527	433	142
15-17 Years	425	187	176	61
18-19 Years	678	340	257	81

RATE PER 1,000 WOMEN

AGE OF WOMEN	1976 ALL PREGNANCIES	1976 LIVE BIRTHS	1976 INDUCED ABORTIONS	1976 FETAL DEATHS	1978 ALL PREGNANCIES	1978 LIVE BIRTHS	1978 INDUCED ABORTIONS	1978 FETAL DEATHS
Under 15 Yrs.	3.2	1.2	1.6	0.4	3.2	1.2	1.6	0.4
15-19 Years	101.4	52.8	34.3	14.3	105.1	51.5	39.7	13.9
15-17 Years	NA	NA	NA	NA	69.7	32.2	26.9	10.5
18-19 Years	NA	NA	NA	NA	157.2	79.8	58.4	19.0

AGE OF WOMEN	1981 ALL PREGNANCIES	1981 LIVE BIRTHS	1981 INDUCED ABORTIONS	1981 FETAL DEATHS
Under 15 Yrs.	3.1	1.1	1.7	0.4
15-19 Years	110.3	52.7	43.3	14.2
15-17 Years	72.7	32.1	30.1	10.5
18-19 Years	163.1	81.7	61.9	19.4

Source: Ventura, S.J., Taffel, S. and Mosher, W.D., "Estimates of Pregnancies and Pregnancy Rates for the United States", 1976-1981, Public Health Reports, Jan-Feb 1985, Vol 100, No. 1, Table 1.

TABLE 3

Percentage of teenage mothers' having a first birth who began prenatal care in the first trimester, by marital status at conception and birth and race of child, United States, 1980.

RACE OF CHILD	TOTAL ALL* MARITAL STATUSES	PREMARITAL CONCEPTION		MARITAL CONCEPTION
		UNMARRIED AT BIRTH	MARRIED AT BIRTH	
All races**	35.7	24.1	43.2	52.8
White	38.2	21.3	44.1	52.8
Black	28.8	27.2	33.2***	48.9***

* For married mothers, includes only those married once, husband present

** Includes races other than white and black

*** Does not meet standards of statistical reliablility; that is, the relative standard error is 25 percent or more

Source: Ventura, S.J. & Hendershot, G.E., "Infant Health Consequences of Childbearing by Teenagers and Older Public Health Reports, March-April 1984, Vol. 99, No. 2, Table 6.

TABLE 4

Outcome of first births in terms of three infant health measures for mothers* under 20 years, according to marital status at conception and birth, and trimester of pregnancy prenatal care began, United States, 1980.

TRIMESTER PRENATAL CARE BEGAN AND INFANT HEALTH MEASURE	TOTAL ALL MARITAL STATUSES	UNMARRIED AT BIRTH	MARRIED AT BIRTH	MARITAL CONCEPTION
ALL MOTHERS				
Fetal losses per 1,000 births	5.2	5.6	3.8	5.9
Percent of infants weighing less than 2,500 gm	8.9	10.8	7.4	6.2
Percent of infants with 1-minute Apgar scores less than 7	10.4	11.1	10.1	9.2
FIRST TRIMESTER				
Fetal losses per 1,000 births	4.8	6.1	3.2	4.8
Percent of infants weighing less than 2,500 gm	8.3	13.4	6.1**	5.2**
Percent of infants with 1-minute Apgar scores less than 7	12.1	15.7	11.5**	9.1**

* For married mothers, includes only those married once husband present

** Does not meet standards of statistical reliability that is the relative standard error is 25% or more

Source: Ventura & Hendershot, 1984, Table 5.

TABLE 5

Percentage of Women Aged 15-19 Who Ever Were Pregnant Before Marriage, for all Women and Those Who Ever had Premarital Intercourse, by Race, 1971, 1976 and 1979.

Women aged 15-19	1971			1976			1979			1982		
	Total	White	Black	Total	White	Black	Total	White	Black	Total	White	Black
All												
%	8.5	5.6	25.3	13.0	10.0	26.5	16.2	13.5	30.0	13.5	10.6	28.2
(N)	(2,739)	(1,758)	(981)	(1,449)	(880)	(569)	(1,717)	(1,034)	(683)			
Had premarital intercourse												
%	28.1	21.4	47.2	30.0	26.1	40.1	32.5	29.0	45.4	30.0	24.4	52.4
(N)	(958)	(445)	(513)	(726)	(349)	(377)	(938)	(479)	(459)			

Source: Unpublished tabulations from the NSFG-III;
Zelnik and Kantner, 1980: Table 3.

EXHIBIT A

DuSable Clinic
DuSable High School
Chicago Public Schools

CONSENT TO ENROLL MINOR IN

DuSABLE CLINIC

NAME OF MINOR: _____

ADDRESS: _____

BIRTHDATE: _____ PHONE #: _____

I do hereby request, authorize, and consent to the enrollment of my son/daughter or minor for whom I am legal guardian in the DuSable Clinic.

I understand that all services are free, and that I will not be charged for any services my son/daughter receives in the Clinic.

I understand that my signing this consent allows the physicians and professional Clinic staff of the DuSable Clinic to provide the following comprehensive health services:

1. Emergency treatment
2. Routine school and sports physical exams
3. Immunizations
4. Appropriate laboratory tests
5. Examination, diagnosis, and treatment of complaints of pain or ill being identified by my child
6. On-going care of existing medical conditions
7. Treatment of sexually transmitted diseases
8. Pregnancy testing, prenatal and post partum examinations
9. Family planning, including pregnancy prevention
10. Professional counseling in regards to nutrition, personal hygiene, sexuality, substance abuse, family and relationship issues and other health related areas

For further information about the Clinic or any of its services, feel free to call _____ or drop into the Clinic, Room _____ DuSable High School.

PARENTAL CONSENT FOR HEALTH SERVICES

I do hereby give my informed consent for my son/daughter _____ to receive the services offered by the DuSable Health Clinic and to complete confidential questionnaires. Furthermore, I release the Chicago Board of Education and its members, officers, employees, agents and representatives from any and all claims, suits, actions, liabilities, legal costs, and attorneys' fees arising out of the operation of the DuSable Health Clinic.

_____ _____
Signature of Parent/Guardian Date

TABLE 6

Percentage of Never Married Women Aged 15-19 Who Ever Had Intercourse, by Race, U.S. 1971, 1976, 1979, 1982.

	1971 - Zelnik-Kanter			1976 - Zelnik-Kantner			1979 - Zelnik-Kantner			1982-NSFG		
AGE	TOTAL	White	Black	Total	White	Black	Total	White	Black	Total	White	Black
Total	27.6	23.2	52.4	39.2	33.6	64.3	46.0	42.3	64.8	42.2	40.3	52.9
15	14.4	11.3	31.2	18.6	13.8	38.9	22.5	18.3	41.4	17.8	17.3	23.2
16	20.9	17.0	44.4	28.9	23.7	55.1	37.8	35.4	50.4	28.1	26.9	36.3
17	26.1	20.2	58.9	42.9	36.1	71.0	48.5	44.1	73.3	41.0	39.5	46.7
18	39.7	35.6	60.2	51.4	46.0	76.2	56.9	52.6	76.3	52.7	48.6	75.7
19	46.4	40.7	78.3	59.5	53.6	83.9	69.0	64.9	88.5	61.7	59.3	78.0

Source: Unpublished Tabulations from the NSFG, Cycle III, 1982;
Unpublished Tabulations from the National Longitudinal Survey of Youth, 1983; Zelnik and Kantner, 1980, Table 1.

TABLE 7

Percent of Sexually Experienced Never-Married Women Aged 15-19 Who Had Intercourse Only Once, by Age and Race, 1976.

AGE	RACE				
	ALL	WHITE		BLACK	
		%	N	%	N
15-19	14.8	14.3	379	12.7	410
15-17	19.9	18.4	206	18.4	217
18-19	8.6	9.3	173	6.2	193

Source: Zelnik & Kanther, 1977, Table 2

TABLE 8

Distribution (in Percentages) of Intercourse in the 4 Weeks Preceding Interview Among Never Married Women Aged 15 to 19, by Race: 1971, 1976, and 1979.

Frequency of Intercourse*	1971			1976			1979		
	Total (n=777)	White (n=330)	Black (n=447)	Total (n=590)	White (n=247)	Black (n=343)	Total (n=809)	White (n=388)	Black (n=421)
0	38.3	36.9	41.7	47.5	45.7	51.8	41.8	40.2	46.8
1-2	31.3	30.6	32.3	22.2	19.7	28.0	24.6	23.9	26.7
3-5	17.7	17.5	18.1	15.0	15.9	13.0	14.1	13.3	16.5
6 or more	12.9	15.0	7.9	15.3	18.8	7.2	19.5	22.6	10.0
Mean	NA	NA	NA	2.9	3.4	1.7	3.7	4.1	2.3

*In the 1971 survey these precoded categories were used; in the 1976 and 1979 surveys individual responses were recorded.

NA: not available

Source: Zelnik, 1983, Table 2-7.

SUMMARY OF 1983 AND 1984 ACTIVITIES

The Select Committee on Children, Youth, and Families was created by the 98th Congress in 1983 to provide an ongoing assessment of the conditions of American children and families, and to make recommendations to Congress and the public about how to improve public and private sector policies for this constituency.

The following is a list of the activities conducted by the Select Committee during the 98th Congress.

98TH CONGRESS

HEARINGS CONDUCTED

1983

Beginning the Assessment
Washington, D.C.

Prevention Strategies for Healthy Babies and Healthy Children
(Prevention Strategies Task Force)
Washington, D.C.

Families in Crisis: The Private Sector Response
(Crisis Intervention Task Force)
Washington, D.C.

Supporting a Family: Providing the Basics
(Economic Security Task Force)
Washington, D.C.

Teen Parents and Their Children: Issues and Programs
(Prevention Strategies Task Force)
Washington, D.C.

Children, Youth, and Families in the Northeast
New York, New York

Children's Fears of War
Washington, D.C.

Children, Youth, and Families in the Midwest
St. Paul, Minnesota

Children, Youth, and Families in the Southeast
Miami, Florida

Teenagers in Crisis: Issues and Programs
(Crisis Intervention Task Force)
Washington, D.C.

Paternal Absence and Fathers' Roles
(Economic Security Task Force)
Washington, D.C.

Children, Youth, and Families in the Mountain West
Salt Lake City, Utah

Children, Youth, and Families in the Southwest
Santa Ana, California

1984

The New Unemployed: Long-Term Consequences for Their Families
Detroit, Michigan

Child Abuse: What We Know About Prevention Strategies
(Prevention Strategies Task Force)
Washington, D.C.

Child Care: Beginning A National Initiative
Washington, D.C.

Working Families: Issues for the 80's
Hamden, Connecticut

Youth and the Justice System: Can We Intervene Earlier?
Crisis Intervention Task Force)
New Orleans, Louisiana

Child Care: Exploring Private and Public Sector Approaches
Irving, (Dallas/Fort Worth), Texas

Improving American Education: Roles for Parents
(Prevention Strategies Task Force)
Washington, D.C.

Violence and Abuse in American Families
Washington, D.C.

Child Care: Exploring Private and Public Sector Approaches
San Francisco, California

Child Care: Improving Child Care Services What Can Be Done?
Washington, D.C.

Child Care: Child Abuse and Day Care
(Jointly held with Committee on Ways and Means Subcommittee on Oversight)
Washington, D.C.

SITES VISITED

1983

Under 21, Covenant House, - New York, New York
(Multiservice program and long-term emergency shelter for runaway and homeless youth)

Hotel Martinique - New York, New York
(Housing for homeless families)

St. Paul Maternal and Infant Care Project, St. Paul Central High School - St. Paul, Minnesota
(High school clinic, education and day care program)

Mailman Center for Child Development and Jackson Memorial Hospital - Miami, Florida
(including Neonatal Intensive Care Unit, University of Miami)

Primary Children's Medical Center - Salt Lake City, Utah
(including In-Patient Treatment Program, Department of Child Psychiatry; Intermountain Pediatric Trauma Center; and Infant Intensive Care Unit)

Orange County Youth Guidance Center - Santa Ana, California
(temporary facility for nonviolent criminal offenders aged 13 to 18)

1984

Project Bridge - Detroit, Michigan
(job-seeking skills and retraining program run by Jewish Vocational Services)

Leila Day Nursery - New Haven, Connecticut
(the nation's oldest child care center for children of working parents)

Adolescent Service Center - New Orleans, Louisiana
(specialized education and counseling services to junior high school students with disciplinary problems, and their parents, to prevent school drop-out)

Zale Corporation Child Care Center -Irving (Dallas/Fort Worth), Texas
(on-site corporate child care center)

Child Care/Study Center, University of California at San Francisco -
(preschool for students, employees and the community)

REPORTS ISSUED

1983

U.S. Children and Their Families: Current Conditions and Recent Trends - This report represents a concise statistical summary of national data on population, family environment, income, education, health and health related behavior, behavior and attitudes and selected government programs affecting children.

Demographic and Social Trends: Implications for Federal Support of Dependent Care Services for Children and the Elderly - This study, prepared by the Congressional Budget Office, analyzes how population growth, economic trends, and changes in the workplace in the 1980's could affect the two groups most traditionally in need of dependent care -- very young children and very elderly adults. The paper looks at how demand for these services might change, as well as which Federal policy options could address the changing service needs.

Federal Programs Affecting Children - This report, prepared by the Congressional Research Service, is the most comprehensive available compilation of Federal programs affecting children in the area of income maintenance, nutrition, social services, education, health, housing and taxation. Each summary includes the program's legislative authority, the agencies administering the program, a brief description of the program, and information on participating and funding levels.

1984

Children, Youth, and Families: 1983 - This report is based on the 1983 activities of the Committee. It synthesizes testimony of more than 170 witnesses, as well as information developed through site visits and reports. The report includes the Committee's major findings after its first year.

Families and Child Care: Improving the Options - This report is the culmination of a bipartisan, nationwide initiative on child care - the first of its kind in more than a decade. It includes specific findings and recommendations for legislative action. It is a comprehensive report on child care around the country based on testimony of over 170 witnesses.

DISSENTING MINORITY VIEWS OF HON. DAN COATS, RANKING MINORITY MEMBER; HON. HAMILTON FISH, JR.; HON. THOMAS J. BLILEY, JR.; HON. FRANK R. WOLF; HON. DAN BURTON; HON. NANCY L. JOHNSON; HON. BARBARA V. VUCANOVICH; HON. DAVID S. MONSON; AND HON. ROBERT C. SMITH

INTRODUCTION

Committee Continues To Serve Valuable Role

This year-end report illustrates the continued valuable contributions the House Select Committee on Children, Youth and Families is making to the political debate in Washington. Too often families and their children get lost in the shuffle as more powerful and better organized interests dominate discussion.

This Committee plays a unique role in focusing on issues that effect the family. While on this Committee we may disagree what solutions should be pursued, or even precise definitions of the problems, we do agree on the primary importance of the family in American life and the vital importance of focusing on these issues.

Those who have attended Committee hearings or who have read the individual hearing reports know that we have had lively discussions that have tried to define the problems, highlight those problems and listen to those who have developed creative solutions.

While this year-end report gives an excellent overall picture of the Committee's 1985 activities, on a hearing-by-hearing basis it is not and, by design, cannot be, comprehensive.

Reasons For Dissenting Minority Views

While this year-end report is a valuable overview of 1985, it should be clear that it is a document developed by the Majority Staff. Differences on witness summaries are sometimes minimal and sometimes substantive. More importantly, by including fact sheets developed by Majority staff in this year-end report, it goes beyond just a relatively straight-forward summary of our hearings.

As all who are involved in public policy are aware, facts looked at from different angles can frame problems in different ways. We also know that the difference between a "fact" and an "opinion" is often marginal at best. Furthermore, we know that once commonly accepted as "facts", these facts drive public policy solutions.

Therefore, we felt that dissenting views were essential for the following reasons:

1) The Minority did not participate in drafting the Fact Sheets and therefore is not prepared to categorically accept them.

2) It is clear by just sampling these Fact Sheets that the collection of facts listed are there to develop a point-of-view (i.e. they are selective)

3) For some hearings this is of little concern. Most, if not all, Minority Members would agree with what are the most relevant facts. BUT for some hearings it is very important (e.g. taxes and child exploitation/pornography).

4) For most hearings, Minority concerns lie somewhere in between. The Majority facts are not inaccurate but they don't tell the whole story.

Format Of These Dissenting Views

It should be clearly noted that the following views are not a comprehensive look at each subject we discussed this year. Each hearing record contains both the Majority and Minority input on that issue.

The purpose of these dissenting views is to illustrate our different emphasis, particularly highlighting a few examples of why the Minority did not agree to approve this Report's Fact Sheets.

Not all Minority Members will necessarily agree with all the Minority "Key Facts" or concerns about the Majority's Fact Sheets, but we do share a common agreement that we cannot support the inclusion of the Majority's Fact Sheets.

For each of the 1985 hearings, in the same order as they appear in the report, it will be noted if there are examples of concerns we have with witness summaries, or with disputed facts, as well as additional facts when they further clarify a hearing or the Minority's approach to a hearing.

Signs Of A Strong Committee

The disagreements on this Committee are an indication of its value. In 1985 we have had a year of largely constructive dialogue on how to approach these most difficult of issues facing American families. We may strongly disagree on some solutions, but the common concern we share for the future of the family and our children has resulted in a continuing record of valuable hearings and reports.

Hearing-By-Hearing Minority Response

Page

1) Alcohol Abuse (two hearings).....124
2) Families with Disabled Children.....125
3) Tax Policy.....126
4) Adolescent Mental Health Trends.....131
5) Learning from Private Sector/Foundations....133
6) Child Care Insurance Crisis (two hearings)..135
7) Melting Pot: Fact or Fiction?.....136
8) Child Victims of Exploitation.....138
9) Children and Families in Poverty.....143
10) Sudden Infant Death Syndrome.....146

ALCOHOL ABUSE AND THE FAMILY: PARTS I AND II

Two hearings were held on alcohol abuse: the first focused primarily on the incidence of alcohol abuse in families and the second focused on prevention activities. While the notion of family was incorporated into the titles of both hearings, the witnesses tended to direct their remarks to individual functioning and treatment approaches rather than family system functioning and treatment.

In the Second Special Report to the U.S. Congress on Alcohol and Health, family therapy was referred to as the most noteworthy advance in the treatment of alcoholics. This type of therapy is based on the notion that alcoholism is a family disease; when one family member is an alcoholic it affects all of the members of the family. The underlying assumption is that prevention activities that are directed solely to the individual are less likely to be as effective as treatment efforts directed to the family as a system. In short, family therapy assumes that successful recovery of the alcoholic will require the support of family. Finally, family therapy assumes that new behaviors and attitudes will have to be developed by each member of the family to end the abuse of alcohol.

Key Facts

* The latest Gallup Poll on alcohol abuse showed that 8 out of 10 Americans believe alcohol abuse to be a major national problem. (Gallup, 1983)

* The average age at which people begin to drink is 13, and by age 10, 20 percent of children have tried alcohol at least once. (ADAMHA, 1985)

* More senior high school students use alcohol than any other psychoactive drug. 92% of all seniors have tried alcohol and 40% have had five or more drinks in a row at least once in the past two weeks. (HHS, 1985)

* More than 10.5 million American adults are problem drinkers. In addition, an estimated 3.3 million teenagers between the ages of 14 and 17 are experiencing problems with the use of alcohol. (ADAMHA, 1985)

* It is estimated that 83% of OUI (Operating Under the Influence) first offenders coming before the court are alcoholics or problem drinkers. (Judge Al Kramer, CYF Hearing, 1985)

* It is estimated that in 1983 the economic cost of alcohol abuse amounted to about $116.7 billion, including lost productivity and medical care. (ADAMHA, 1985)

* 40% of all family court problems involve alcoholism. (HHS, 1983)

* Alcoholism is involved in 50% of cases of spouse abuse. (HHS, 1983)

ADAMHA -- Alcohol, Drug Abuse, and Mental Health Administration.
HHS -- Health and Human Services
CYF Hearing -- "Alcohol Abuse and the Family," March 18

FAMILIES WITH DISABLED CHILDREN: ISSUES FOR THE EIGHTIES

Key Facts

* Funding for just one program to serve disabled children gives an example of the extent of federal support for these children.

FISCAL YEAR	CHILDREN SERVED	FEDERAL FUNDING (in thousands)
1977	3,485	$251,769
1981	3,941	874,500
1986	4,153	1,215,550

(Education of the Handicapped, Congressional Research Service Issue Brief, 1986)

* Four premises about how to help families with disabled children be successful:

1. Families need help in attending to the extraordinary needs of their children on a day in and day out basis;

2. Families are infinitely diverse;

3. Balance is a key to successful family life;

4. Families change over the life cycle.

(Dr. Ann Turnbull, Testimony before House Select Committee on Children, Youth, and Families, 1985)

TAX POLICY

The fundamental difference between Majority and Minority perceptions of the problems in the federal government's tax treatment of families is well-summarized in the titles which either side chose for the tax hearing. While developing the hearing, the Minority used the working title, "Tax Fairness for Families." The Majority finally named the hearing, "Tax Policy: What Do Families Need?"

The tax code is a poor instrument with which to address the needs of families, or of anybody. It is primarily the instrument which takes money from individuals and families in order to pay for services which do address individuals' and families' needs. Our chief concerns ought to be that it do so efficiently and, above all, fairly. Over the past two and a half decades, families have been treated with increasing unfairness. This unfairness results primarily from the devaluation of the personal exemption which taxpayers take for themselves, their spouses and their dependents.

Key Facts

In CYF hearings, it has become evident that average American families are finding it increasingly more difficult to bear the financial burdens of raising children.

* Mothers of small children are forced into the labor market because a second income is becoming a necessity.

* Even with a second income, families find they cannot afford the high cost of quality day care so that their children will be well cared for while the parents work.

Average family income has increased dramatically over the past three and a half decades.

* In real terms, the median family income has increased markedly over the past three decades, The chart below shows that the median family income nearly doubled between 1950 and 1979, though it declined nine percent from 1979 to 1983.

MEDIAN FAMILY INCOMES IN CONSTANT DOLLARS (1983)

	1950	1960	1970	1979	1983
All families	$13,736	18,907	25,317	26,885	24,580
Two Parent One income	13,720	18,570	23,872	24,363	21,890
Two Parent Two Income	16,567	23,213	31,497	34,256	32,107

Figures from U.S. Bureau of the Census

The personal exemption has not kept up with income growth or inflation.

* In 1948, the personal exemption was set at $600. By 1979, the exemption was raised to $1,000, and was finally indexed for inflation in 1985.

* If the personal exemption had been indexed since 1948, it would be worth $2,600 in 1985.

* If it were to offset the same percentage of average income as it did in 1948, it would be worth about $5,600.

The devaluation of the personal exemption has caused the federal tax burden to shift disproportionately onto the backs of families with children.

* For single persons and couples without children, increased exclusions from adjusted income, itemized deductions, and tax credits have offset the decreased value of the exemption. As a result, these persons face almost the same average effective tax rates in 1984 as they did in 1960.

* In 1984, the average income couple with two dependents had an effective income tax rate 43% higher than in 1960, while a couple with four dependents faced a 223% rate.

The current personal exemption recognizes less than one fourth of what the average family spends on its children and only one half of what it costs to raise a child in poverty.

* The average cost of raising a child to age 18 in a middle income family with two children and wife employed part time was estimated at $84,400 in 1981. Divided by 18, that works out to $4,578 per child per year.

* The official U.S. poverty threshold is increased an average of $2,047 for every child added to a family.

This tax increase falls most heavily on those racial and ethnic groups which are also most economically vulnerable.

* Today, about 50% of all American families have children under 18 years of age; However, 60% of black families, and almost 70% of Hispanic families have children under 18.

* In 1960, 36% of all American families with children under 18 had three or more children. By 1983, that figure had dropped by more than a third, to 21%. But 31% of Hispanic families and 29% of black families had three or more children.

Comments On Majority Fact Sheet

Majority Fact Sheet: Economic supports for children have eroded.

Minority Response:

Contrary to what is implied by the Majority Fact Sheet, the personal exemption is not an "economic support." It is not a handout to families. It is simply the recognition of the

differences in ability to pay among persons with equal incomes but different numbers of dependents. Just as our tax code adjusts tax liability according to a taxpayer's income and necessary expenses, so also does it adjust tax liability according to minimum amount of expenses for dependents.

To imply that the personal exemption is a kind of economic support for families rather than a basic provision of fairness is to leave the door wide open for denying the full personal exemption to any but low income persons.

Majority Fact Sheet: Low income families are losing ground. Between 1972 and 1984, the average total real income of a working poor single mother of 3, including poverty level wages, AFDC, Food Stamps and tax benefits declined by over 22% from $13,361 to $10,372 in 1984 dollars.

Minority Response:

In 1984, the Select Committee issued a report entitled Federal Programs Affecting Children. This report listed 71 seperate federal programs affecting children, youth, and families: 12 income maintenance programs, 9 nutrition programs, 19 social service programs, 12 education and training programs, 11 health programs, 4 housing programs, and 4 tax provisions. Most of these programs are targeted to low-income families. Many of these programs did not exist in 1972; others have experienced dramatic increases in spending levels and broadening of eligibility standards since the early 70's. These programs include:

PROGRAM	1983 FUNDING LEVEL (in millions)
Child Support Enforcement	$347.5
Supplemental Security Income	8,500.0
Social Security Dependents Benefits	10,900.0
National School Lunch Program	2,267.4
School Breakfast Program	327.0
Child Care Food Program	328.8
Summer Food Service Program	100.3
Commodity Assistance for Child Nutrition Program	459.5
Special Supplemental Food Program for Women Infants and Children	1,160.0
Social Services Block Grant	2,675.0
Head Start	912.0
Compensatory Education for Disadvantaged Children	3,200.0
Education Block Grant	479.4
Job Training Partnership Act	3,394.0
Medicaid	3,600.0 (1982)
Maternal and Child Health Services Block Grant	478.0
Family Planning	124.1
Public Housing	3,300.0
Leased Housing Assistance	4,900.0
Home Ownership Assistance	284.0
Rental Housing Assistance	665.0

A true assessment of whether low income families are losing ground, and whether that loss is due to decreases in federal

expenditures, must take into account more than AFDC, Food Stamps, and tax provisions. In addition to the 71 federal programs listed in "Federal Programs Affecting Children," a true assessment must also take into account changes in policies and progams at the state and local levels, and private efforts.

Majority Fact Sheet: Tax Burdens are not evenly distributed among families--
Changes in federal tax laws in 1981 and 1982 provided average tax reductions for families with incomes under $10,000 of $70 (between 1983 and 1985), $9,060 for families with incomes between $40,000 and $80,000, and $24,600 for families with incomes $80,000 and over.

Minority Response:

These estimates in tax liability reductions for families at different income levels come from 1984 CBO estimates. These estimates were actually done for households, not families. An individual can be a household, but he is not a family; so the Majority statement is not quite an accurate presentation of what CBO calculated.

But ignoring that difference, there still remain questions about the real significance of these figures. Comparing a $70 reduction in tax liability to a $9,060 reduction makes little sense unless one knows what these numbers are reductions from. Unfortunately, CBO did not include these figures in its published paper; and reconstruction of the process through which they calculated the deductions would be a time-consuming task. Some perspective is provided, however, by other 1984 CBO estimates on the changes in percentage of total tax liability (i.e. what percentage each group contributed to all taxes collected) for households at different income levels. These estimates (see chart on next page) show that households with incomes less than $40,000 paid a smaller share of all taxes after 1982 while households with incomes greater than $40,000 paid a larger share.

Minority Members are opposed to the taxation of families in poverty. But ERTA and TEFRA are not responsible for the fact that poverty level families now pay taxes. Rather, failure to adequately increase the personal exemption over a period of many years is responsible for this unjust policy.

PERCENTAGE OF TOTAL INCOME TAX LIABILITY PAID
BY INCOME CATEGORY, CALENDAR YEARS 1982-1985

Percentage of Total Income Tax Liability	All Households	Household Income (In current dollars) Less Than $10,000	$10,000-20,000	$20,000-40,000	$40,000-80,000	$80,000 and Over
Under Prior Law:						
1982	100.0	0.6	7.6	36.0	38.4	17.5
After ERTA and TEFRA:						
1982	100.0	0.6	7.6	36.1	38.5	17.3
1983	100.0	0.5	6.9	33.8	39.4	19.3
1984	100.0	0.5	6.1	31.5	40.7	21.3
1985	100.0	0.4	5.2	29.2	42.0	23.2

(CBO, 1984)

Majority Fact Sheets: Family Income Is Declining -- Over the past five years, median family income has declined by over 9% in real terms, from $26,885 in 1979 to $24,580 in 1983.

Minority Response:

By considering a very narrow range of years, the Majority gives a misleading picture of the trends in family incomes. A truer picture has been provided in the Minority's compilation of KEY FACTS. The last year for which the Bureau of Census has figures for median family income is 1984. Between 1983 and 1984, income in real terms increased at a faster rate than it had decreased in the five previous years. Median family income in 1984 was $25,354 (in 1983 dollars), representing less than a 6% decline from 1979, a slight increase over 1970, a 34% increase over 1960, and a 85% increase over 1950. These figures represent increases in constant dollars. In addition, steady improvement in the economy since 1983 leads us to expect even greater increases in median family income for 1985 and 1986.

EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS

The major trend cited in Mental Health Care for Adolescents is the apparent increasing use of in-patient hospitalization. However, the Minority believes there are several ways to interpret this:

- The increase is due to "unnecessary" confinement of troubled teens "for profit".
- The confinement could be due to a rise in the number and severity of severely emotionally disturbed teens.
- Or, finally, the increase might be due to heightened sensitivity by parents of the known benefits of early intervention.

The Majority relied solely on the first interpretation i.e., the increase in hospital admissions is linked to the availabiliity of third party health insurance reimbursement.

Testimony Summaries

Ira Schwartz

What needs to be pointed out in Ira Schwartz's testimony is that the data presented (then repeated throughout the fact sheet) is Minnesota data only--to the extent that it is accurate it is not generalizable to the rest of the country. The source of the data presented in the testimony is questionable--the source of the very powerful statement that "juvenile admissions to private psychiatric hospitals increased 450% between 1980 and 1984" is a CBS TV show. Yet this source was attributed to Ira Schwartz, when in fact his source was a TV show not research of his own. (Which he noted but the summary did not.)

James Egan

The Majority summary failed to include the criteria that mental health professionals use in recommending hospitalization. "Decisions for admission of children and adolescents for in-patient treatment are based upon severity of functional impairments rather than diagnoses, since diagnoses are poorly correlated with the degree of impairment or need for or length of in-patient treatment. In addition, in-patient treatment is recommended only when a lesser level of care will not be effective or is not available." Dr. Egan stressed that there are many levels of review of the appropriateness of in-patient psychiatric hospitalization for teens.

Key Facts

In 1984 Congress appropriated $1.5 million to develop a new initiative to improve service delivery systems for severely emotionally disturbed (SED) children and adolescents. CASSP was developed in response to that mandate; and in 1985 Congress increased its appropriation for CASSP to $3.9 million. The major goals of CASSP are: to improve the availability of continuum of services for SED children; to develop and/or expand leadership capacity at the State level for child mental health programs; to establish coordination mechanisms; and to develop program evaluation capacity. The NIMH CASSP has 3 components: the grant program; the technical assistance and research program; and the evaluation program. (NIH, 1985)

The Grant Program

* In FY 1984 NIMH received 44 CASSP applications, awarded 10 grants (totaling $1.2 million) and developed a $.3 million technical

assistance and research program. Grants were awarded to Alabama, Alaska, Georgia, Hawaii, Kansas, Maine, Mississippi, New Jersey, Ohio and Wisconsin.

* In FY 1985 NIMH awarded 4 new grants from the FY 84 applications adding Indiana, Nebraska, Pennsylvania, and Vermont to the original 10. In response to the FY 85 grant announcement, 22 new applications were received, of which 8 additional new grants will be awarded. With 10 continuations of the FY 84 grants, the total will be 22 grants totaling a $3.3 million and an increased technical assistance and research program of $.6 million.

* Each CASSP grant supports the creation of a State-level focus for severely emotionally disturbed children and encourages the development of a coalition of mental health, health, education, welfare and juvenile justice agencies to assure the appropriate provision of services to the target population. Once the focal point has been established, the State must conduct an assessment of its service system for SED children identifying service gaps and barriers and developing needed service options and mechanisms for overcoming barriers. CASSP then supports the translation and replication of this systems improvement capacity at the community level through the provision of training and technical assistance to local communities within the CASSP State. (NIH, 1985)

* There is consensus in the psychiatric community that early intervention will likely prevent future problems and enable these children to lead productive adult lives. (President's Commission, 1978)

LEARNING FROM THE PRIVATE SECTOR: A DIALOGUE WITH FOUNDATION EXECUTIVES

Private foundations and corporations alike have a fundamental responsibility to society in general and to families in particular. The withdrawal of federal money has made it increasingly important that philanthropic groups not only increase their charitable giving, but focus their attention on activities designed to strengthen families.

Foundations represent a very small part of philanthropy. From 1977 to 1984, voluntary contributions more than doubled, totalling $74.25 billion. The shift from federal support for social services to more reliance on private support means that foundations will have to start doing things differently. For example, the trend is already evident that foundations will tend to make fewer, more meaningful grants rather than numerous small ones. However, it is important that seed money be available to start up alternative model programs in the hope that these programs will work and eventually become self-sustaining. It is also clear that foundations must move toward greater community involvement in decisions about the types of programming that will affect a community. Lastly, there needs to be greater cooperation and partnership established between federal government and foundations, as well as among donors, to ensure the equitable distribution of funds.

Testimony Summaries

* All of the Foundation Executives agreed that Foundations do best when they support activities that are pro-active, and focus on prevention.

* Foundations agree that they cannot match dollar for dollar the redistribution of federal money. However, they also agree that their growing investments are a reflection of a healthy economy.

* There seems to be disagreement concerning the appropriate role of foundations. While the Minority would encourage them to disseminate and publish all research reports that have policy relevance, we hesitate to encourage them to actively lobby for a position. The Majority appeared to confuse the issue of information dissemination with active lobbying and was actively soliciting the support of foundations to play an advocate role.

The Majority said that they would continue this dialogue with foundations to elicit their active (and partisan) support. The Minority believes that foundations as "think tanks" have an important role to inform policy makers of programs that work, or research findings that indicate that doing "X" maintains healthy families, but doing "Y" invites their collapse. <u>However, advocating for a policy position would in the long run politicize research information and render it less useful</u>.

The panels basically discussed their own foundation work and activites of interest to the Committee. For example, the Clark Foundation has a focus on prevention of unnecessary foster care and Johnson's foundation targets the prevention of low-birth-weight babies; Skillman funds a wide range of activities geared towards youth. Carnegie, though broad based, also directs money to combat school failure.

Key Facts

* There are approximately 22,000 active grantmaking foundations in the U.S., however, only 17 percent of these hold assets of one million dollars or more. (American Association of Fund-Raising Counsel, Inc., Annual Report, 1985)

* In 1981, there were only 144 foundations with assets of $50 million or more, yet this group held over half of all foundation assets, and awarded nearly 35% of all foundation grant dollars. (AAFRC)

* Larger foundations account for about 80% of the total number of grantmaking foundations, and are responsible for about 75% of the foundation grant dollars awarded annually. (AAFRC)

* Company sponsored foundations are the fastest growing segment of grantmaking foundations with assets of one million dollars or more. A company sponsored foundation usually maintains close ties with the parent company which has provided its endowments and continues to make annual contributions to it. (AAFRC, 1985)

* Following a general pattern which began in 1980, foundations continue to place a strong emphasis on funding within the general welfare category - a category which now accounts for 28.4% of the total dollars and 34.1% of the total number of grants reported. (AAFRC, 1985)

* America's gift-supported organizations, institutions and agencies received a record braking $75.25 billion through voluntary contributions in 1984. (AAFRC, 1985)

* Individual giving represents the largest portion of all charitable contributions (83%). (AAFRC, 1985)

* Corporate giving has increased to $3.45 billion, yet this represents less than 5% of the total giving to charitable causes. (AAFRC, 1985)

* Foundation giving accounted for $4.36 billion, which represents 5.8% of all philanthropy in 1984. (AAFRC, 1985)

* The largest single share of all the charitable giving last year went to religion, followed by health, education, social services, arts. (AAFRC, 1985)

* As a portion of all philanthropy in U.S., giving to social services accounted for 10.7 % in 1984. This represents $8.01 billion in 1984. (AAFRC, 1985)

CHILD CARE: EMERGING INSURANCE CRISIS
(Two hearings)

Testimony Summaries

The Majority summary did not emphasize Commissioner Muhl's explanation of the reason for the crisis. Yet these facts are key to understanding this crisis.

- The business of insurance has traditionally been cyclical which usually results in negative underwriting at the low end of any given cycle. The present cycle is much different than the norm and much more severe. Due to the financial concerns of many companies and the partial withdrawal of the reinsurance facilities, the U.S. market does not have the capacity to fill the insurance needs of everyone as they did in 1984 and in previous years.

- The insurers are having to decide whether to place their remaining capacity in more at-risk lines or to place it in more traditional lines where they have been known to make a reasonable profit at less risk.

- Day care facilities are not the only ones affected by this capacity shortfall in that we have a growing list which includes nurse mid-wives, obstetricians, neurosurgeons, municipalities and counties, long-haul truckers, facilities dealing with hazardous waste, dram shops, certified public accountants, architects and engineers, lawyers, rental care companies and so on.

- The day care facilities have been caught up in this availability but are being deemed higher risk, not based on claims but due more to an insurance hysteria because of the adverse national publicity associated with child abuse situations.

- SOLUTIONS: it is important to create a dialogue with insurance companies that are underwriting day care facilities and separate the issue of child abuse from the usual costs of doing day care business.

- In addition, it seems that policy provisions can be amended to exclude certain coverages if a particular day care facility is found to have participated in the abuse of children.

- Some insurers are shying away from covering certain types of risks at any price. If there is no way of figuring what kind of damage a jury might award to the parents of a child molested at a day care center, for example, then the companies will find it best to stop writing that kind of insurance at all. Says James Wood, a member of a firm of actuaries whose headquarters are in Atlanta: "If you are an insurer and have $100,000 in assets, do you want to risk those assets to keep day care centers open? The answer is probably no, because you do not know what you have to charge when you do not know what the ultimate costs of providing the coverage might be." (Time Magazine, March 24, 1986)

MELTING POT: FACT OR FICTION?

Key Facts

* MEDIAN HOUSEHOLD INCOME IN 1979 (BASED ON 1980 CENSUS)

Americans born in the USA	$17,010
Americans born in Mexico	$12,747
Americans born in Italy	$13,736
Americans born in Germany	$15,790
Americans born in Korea	$18,085
Americans born in Mainland China	$18,544
Americans born in the Philipines	$22,787
Americans born in India	$25,644

* COLLEGE EDUCATION ACHIEVED BY THOSE OVER THE AGE OF 25

Americans born in the USA	16.3%
All immigrants	15.8%
Mexican immigrants	3.0%
Italian immigrants	5.0%
German immigrants	15.0%
Mainland Chinese immigrants	30.0%
Korean immigrants	34.0%
Filipino immigrants	43.0%
Indian immigrants	66.0%

(both charts)from "The Not So Huddled Masses" American Demographics May, 1984 article by Bryant Robey

*

	FAMILY INCOME INDEX (U.S. AVERAGE = 100) *1969 Family Income %	**1977 Family Inc %
Jewish	172	**
Japanese	132	--
Polish	115	119
Chinese	112	--
Italian	112	114
German	107	111
Anglo-Saxon	107	113
Irish	103	110
TOTAL US	100	100
Filipino	99	--
West Indian	94	--
Cuban	80	88
Mexican	76	73
Puerto Rican	63	50
Black	62	60
Native American	60	--

* Median family income of each ethnic group divided by the median income of the U.S. population as a whole.

** Comparable data for Jews are not available for both periods, but using Russian-American data as a proxy for Jewish data, as is commonly done in the literature, shows an income percentage of 146 for 1968, 140 for 1970 and a 1977 income percentage of 143.

Source: U.S. Bureau of the Census and National Jewish Population Survey

The following facts are from Ethnic America by Thomas Sowell, who was unable to attend this hearing but submitted information for the written record:

* "Many factors are responsible for these economic differences among the various groups. Age is a major factor that is often overlooked....For example, about 20% of American Indians are forty five or older, while twice that percentage of Polish Americans are that old. Higher income occupations typically require either long periods of education or long years of experience, or both, so it is not surprising that older ethnic groups earn more than younger ethnic groups."
* "Black family life in the early decades of the twentieth century was typically one featuring two parent households. More than four out of five Negro families in New Yo in 1905 were headed by a father. As late as 1925, only 3% of black families in New York were headed by a woman under 20. The unwed teenage welfare mother emerged in a later era."
* "Education is also an obvious influence on income. For every ethnic group, finishing college means an income above the national average."
* "As in the general society, fertility tends to be greatest where people are the poorest: 'The rich get richer, and the poor have children.' In general, those ethnic groups with the lowest incomes - blacks, Puerto Ricans, American Indians, and Mexican Americans - have the highest fertility rates, while Jews and Orientals have too few children to reproduce themselves."
* Hispanics in San Antonio earn 59% of the income of non-Hispanic whites, but in San Diego, Hispanics earn 84% of the income of non-Hispanic whites.

Comments On Majority Fact Sheets

* There is virtually no recognition of minority gains, when in fact many minorities have succeeded (the only "positive" fact was on the success rate in math of Southeast Asian refugee children).
* No acknowledgement was made of the success of previous immigrant groups - the focus was largely on blacks and Hispanics - nor was there any discussion of how past assimilation had been accomplished
* While statistics often illustrated problems related to marriage or related family questions (such as out-of-wedlock teenage pregnancy), the implication is that they were ethnic in origin rather than related to age or family composition
* In this hearing the importance of attitudes, culture, history and other similar variables are critical to the interpetation of facts. Just reading the fact sheets can quickly lead one down the wrong solution road.

CHILD VICTIMS OF EXPLOITATION

Testimony Summaries

Summaries of testimony do not convey the extent to which several subjects, especially pornography and law enforcement, were discussed at this hearing.

John McCain

* Some ∠60 child pornography magazines are sold in this country today.

* Pornography is an $8 billion a year business.

* A study done at Odyssey House, a large New York treatment center, found that many children age 3 through 17 were recruited as models for pornography by organized narcotics rings through their addicted parents. The money earned by the children was then used to feed the narcotics habits of the parents.

* A recent study showed that of 57 advertisements for child related materials advertised in June 1983 issues of the 11 best selling American pornography magazines, 56 listed mailing addresses in the U.S.

Victoria Wagner

* Recommends laws similar to Washington state law passed in 1984, which makes it a felony for an adult to have sex with a minor for purposes of prostitution.

Thomas Berg

* There are two major categories of adults who molest children:
  * pedophiles
  * "regressed offenders"

* True pedophiles are sexually attracted to children, as children.

* The "regressed offender" is attracted to the child because he sees the child as an adult.

* Rates of rehabilitation for these two kinds of child molesters are vastly different:
  * Success rehabilitating regressed offensers is achieved in 90-95% of treated cases. There is no recidivism.
  * Success rehabilitating pedophiles is very low, much like success in trying to "treat" homosexuality.

Bruce Taylor

* Prosecution of adult pornography and prostitution has a significant effect on child pornography and prostitution.

* Traffic in illegal adult and child pornography could be shut down by assigning special prosecutors in 6 to 12 major cities in the U.S -- New York, Los Angeles, Cleveland, Chicago, Washington, Houston, Miami, Boston.

* Postal inspectors and customs agents complain that they are finding child pornography, adult pornography rings that

trade in child pornography, and organized crime figures involved in child pornography, but the U.S. attorney will not bring the cases to trial.

* U.S. attorneys who have prosecuted pornography cases have been successful, but there have not been enough of them.

* There have been policy changes. Customs has turned around almost completely; they are doing a very good job now. Postal inspectors still have not been given the right to bring their cases to the U.S. attorney.

* Current federal penalties for distribution of obscene materials are far too low.

* Organized crime controls hardcore pornography from coast to coast. If you want to open an "adult bookstore," you have to get permission.

* Child pornography has been found in the hands of virtually every major pornography ring. They start out making adult pornography, and end up handling child pornography, too.

Key Facts

Only a small percentage of persons arrested for sexual assault of children receive prison sentences of more than a year.

* Among persons arrested for sexual assault of a child, while 90% are prosecuted, 65% are convicted, 35% are incarcerated, and only 13% are incarcerated for more than a year. (U.S. Department of Justice, 1984)

* Among persons arrested for other sexual offenses against children, while 95% are prosecuted, 81% are convicted, 22% are incarcerated, and only 8% are incarcerated for more than a year. (D.O.J., 1984)

The attorney general's task force on family violence has recommended that judges impose strong sentences for those who sexually victimize children.

The Task Force Report (1984) suggests:

* ...Incest offenders may act with motivations far different than other child molesters and may in some instances be amenable to treatment.

* However, the molester, a stranger or an unrelated, trusted adult, who sexually assaults a child is rarely, if ever susceptible to treatment.

* The only true protection for children from a pedophile is incapacitation of the offender.

States are initiating legal reforms in child sexual abuse cases.

* All states have abolished requirements that a child's testimony, for most instances of alleged sexual abuse, must be corroborated. (American Bar Association, 1985)

* 12 states have adopted special hearsay exceptions by statute or court rule in cases of child sexual abuse. (ABA, 1985)

* 15 states have adopted statutes allowing videotaping and closed-circuit television of a child's testimony. (ABA, 1985)

Pornography victimizes women and children.

* Many women and children victims of sexual assault have testified that their assailants had shown them pornography, or had been known to be regular consumers of violent pornography. (Senate Subcommittee on Juvenile Justice, "Effect of Pornography on Women and Children," 1984)

* Experts agree that pornography is often used by pedophiles to lower the inhibition of their victims to convince children that there is nothing wrong with engaging in sexual activity. (Senate, Permanent Subcommittee on Investigation, "Child Pornography and Pedophilia, 1984)

* Both child and adult pornography is used in the sexual abuse of children. ("Effect of Pornography on Women and Children, 1984)

* Child molesters believe that there is a link between child molestation and pornography. (Testimony of Convicted Child Molesters; Subcommittee on Juvenile Justice, Subcommittee on Investigation, 1984)

* A study by Michigan State Police Detective Lieutenant Darrell Pope demonstrated that, of 38,000 sexual assault cases on file in Michigan, 41% involved some use of pornographic materials just prior to or during the act. (Pope, Darrell, Vice Investigator, Michigan State Police, "Does Pornographic Literature Really Incite Sexual assaults?" 1979)

* In pornography, Black, Asian, and Hispanic women are frequently singled out for particularly abusive treatment based on derogatory ethnic stereotyping. (Andrea Dworkin, 1984)

* In pornography, Anti-Semitic pictorials are set inside "concentration camps" and the sadistic acts that actually took place are presented as sexually pleasurable for the victim. (Ibid.)

* In pornographic "snuff films," women are actually murdered and dismemberment is featured as a sexual act. (Ibid.)

* Up to 75% of the "actresses" or "models" in pornography are thought to be incest victims. They often are individuals who have run away from sexual abuse at home, and who were subsequently "picked up" by pimps. (Ibid.)

* Pornography is used to recruit prostitutes. Rapes are filmed, and the films are used to keep women in prostitution. (Ibid.)

* A recent National Institute of Justice study on sexual homicide in which 36 serial murderers were interviews by FBI agents, revealed that the murderers, in categorizing their highest sexual interest, ranked "pornography" as number one. (Ann Burgess, 1984)

Organized crime controls pornography as a booming business.

* Organized crime dominates the distribution of pornography in the United States. Profits are often invested in other activities, such as loan sharking and narcotics. Pornographers with firm links to organized crime have entered the cable and subscription television industry and they have become major suppliers of pornographic materials to the industry. (State of California, Office of the Attorney General, Bureau of Organized Crime and Criminal Intelligence, "Organized Crime in California, 1982-1983)

* Pornography has become a big business in the United States. Some government officials estimate that pornography is a $4 to $6 billion industry. Other individuals place its gross revenues at closer to $8 billion. (Effect of Pornography on Women and Children)

* There are three to four times more adult bookstores in the United States than McDonald's restaurants. (Dworkin, 1984)

Law enforcement officials have recognized the links between pornography and crime for several years.

* In 1978, an FBI study on the extent of organized crime involvement found:

  * the majority of individuals arrested on sex-related criminal offense have in their possession at the time of arrest some type of pornographic material.

  * organized crime reaps "enormous" profits from pornography which is then redirected to other forms of crime.

  * enforcement of pornography laws throughout the country is both inconsistent and inefficient.

("The Extent of Organized Crime Involvement in Pornography", FBI, 1978)

Pornography hurts families and society.

* Recent studies indicate that exposure to pornography desensitizes individuals and cripples their emotional responses. The studies show that repeated exposure to such materials creates an appetite for more unusual, bizarre, and deviant materials. Repeated exposure leads to sexual dissatisfaction in both men and women; and, most important,

leads to a devaluation of monogamous marriage and a viable institution. (Scott, David, "Pornography - Its Effects on the Family, Community, and Culture, Free Congress Foundation, Washington, D.C.)

* There is a strong correlation between pornographic materials and anti-social behavior. Studies indicate that exposure to films portraying violent sexuality increases male acceptance of violence against women. (Ibid.)

* People who are sexually exploited are often unable to develop healthy, affectionate relationships in later life. They may have sexual dysfunctions, and they may often become victims in a continuous cycle of abuse. (Senate Subcommittee on Juvenile Justice, "Relationship between Child Abuse, Juvenile Delinquency and Adult Criminality," 1983)

CHILDREN AND FAMILIES IN POVERTY

The Minority felt that this hearing should have not relied on individual testimony about how bad poverty is but rather examined some of the root causes of poverty. "Beyond the Statistics" was an inappropriate sub-title since it is hard to get beyond statistics until one understands their meaning.

The Minority had extreme difficulty in scheduling witnesses for this hearing. Several canceled because they felt their "factual" discussion would be out-of-place at this type of hearing, stressing primarily more emotional personal stories.

Key Facts

Source for first group of facts: CRS Report Children in Poverty

* More than half the children in female-headed families are poor--more than two-thirds in such black families. Highest poverty rates are those of never-married mothers.

* Taxes had a larger poverty increasing effect in 1982 than in 1979, reflecting the erosion of the zero bracket amount and the personal exemption in the tax code caused by inflation.

* Overall, a black child was more than twice as likely to be poor as a white child in 1983 (in 1966, the poverty rate of black children had been 4 times that of white children).

* An Hispanic child was more likely to be poor than a white child in 1983.

* Poverty rates are twice as high for children whose mother is 20-24 years old as for those whose mother is 40-44, both for married-couples and single-parent families.

* Studies that follow families over time have found that about two-thirds of children who are ever poor (on an annual basis) during a 15- year period remain in poverty for no more than 4 years. However, 1 poor child out of 7 stays poor for at least 10 of the 15 years and can be considered "persistently" poor. These children spend two-thirds or more of their childhood in poverty.

* Families who experience short-term poverty are demographically similiar to the population as a whole, although blacks and female-headed families are some-what overrepresented. Persistently poor children have a different profile--90% are black. A significant majority lack a father at home and live in the South. Further, they are disproportionately rural.

* The share of children in female-headed families more than doubled from 1959 to 1983 (from 9% to 20%) due to increases in marital dissolution and in births to unwed mothers. If the proportion of children in mother-child families had not increased, it is estimated that there might have been 3 million fewer poor children in 1983.

* More than 70 percent of children with never married mothers, black, white, or Hispanic, lacked enough money to reach the poverty threshold. These children accounted for more than one-eighth of all poor children in 1983.

* Compared with a white child, a black child: was almost 12 times as likely to have a never married mother, was 2.5 times as likely to have a separated or divorced mother, and was 3.5 times as likely to have a widowed mother.

* Incidence of poverty among families with 5 or more children is almost 4 times higher than among families with no more than 2 children.

* The poor child population includes about 40% of children whose mother and father both failed to complete high school, but only 7% of those whose parents each received a diploma.

* When AFDC was enacted, 88% of families that received State welfare were needy because the father had died. AFDC benefits were intended to help the widow care for the children at home. But as time passed, the percentage of AFDC enrollees who were widows and paternal orphans shrank to a tiny minority. And in March 1983 more than 88% of the children had able-bodied but absent fathers; futhermore, the fathers of 47% of AFDC children were not married to their mother.

Source for second group of facts: Mary Jo Bane, Executive Deputy Commissioner, New York State Department of Social Services; "Poverty Among Black Families," September 26, 1985

* The poverty rate among blacks is 46.2%

* 59% of black children are living in situations other than with both parents.

* One-parent families are more likely than two-parent families to be in poverty.

* "Event-caused" poverty, the break-up of a two parent family not in poverty, often makes the mother-child family become poor.

* "Reshuffled" poverty, the break-up of a two-parent family already in poverty, doubles the number of families in poverty; the number of poor individuals remains the same.

* Family structure changes 1960 through late 1970s kept the poverty rate high.

* Family composition contributed little to the increase in poverty from
1979-1983.

* Family composition is but one of several related factors in the persistence of poverty.

Third group of facts: Eleanor Holmes Norton, former Chairman, Equal Opportunity Commission, "Restoring the Traditional Black Family," New York Times Sunday Magazine, 6/2/85

* Two out of three Black women having a first child are single. Over 1/2 of Black children in this country are born to single women.

* Without the large increase in female-headed households, Black family income would have increased by 11% in the late 1970s. Instead, it fell by 5%.

* Perhaps the greatest gap in corrective strategies has been the failure to focus on prevention.

* A primary incubator for ghetto problems is the poor, female-headed households. Stopping its proliferation would prevent a spectrum of often intractable social and economic problems.

SIDS: SUDDEN INFANT DEATH SYNDROME

At the outset the Minority would like the record to show that 8 of the 9 witnesses were affiliated with either the National SIDS Foundation or the American SIDS Institute. The hearing testimony confused primary research funding for SIDS with the total commitment of NICHD to funding SIDS and SIDS related research.

Testimony Summaries

The Majority summary of the only witness not from a SIDS Association i.e., Charlotte S. Catz, M.D. Chief of the Center for Research for Mothers and Children of the National Institute of Child Health and Human Development at the National Institute of Health, was incomplete. It failed to underscore the program objectives of NICHD (which is important in understanding the extent of federal involvement in this issue):

> "The NICHD program objectives have been and continue to be to expand the base of knowledge about the Sudden Infant Death Syndrome: specifically to understand the causes and underlying mechanisms of the syndrome; to identify infants at risk for becoming victims; to explore preventive approaches; to ascertain the epidemiologic characteristics of the SIDS victim, the SIDS family, and the victim's environment, both before and after birth; to clarify the relationship between high risk pregnancy, high risk infancy and SIDS; to search for SIDS-specific lesions; and to elucidate their impact of a sudden and unexpected infant death on parents, siblings, the extended family, and others."

Key Facts

* While the specific funding for SIDS as a seperate disease category has decreased, the funding for SIDS related research i.e., High Risk Infancy and High Risk Pregnancy has continued to be sustained. Funding for High Risk Pregnancy actually increased slightly in 1984 to $10.664 million.

* The estimated FY 1985 obligation for SIDS related research at NIH totals $21.1 million. Three institutes at the NIH fund this research. These institutes are: National Institute of Child Health and Development; National Institute of Neurological and Communicative Disorders and Stroke; and the National Heart, Lung and Blood Institute. (Hearings before the Subcommittee on the Department of Labor, Health and Human Services, Education, and Related Agencies, 1985.)

Dan Coats, Ranking Minority Member
Hamilton Fish, Jr.
Thomas J. Bliley, Jr.
Frank R. Wolf
Dan Burton
Nancy L. Johnson
Barbara F. Vucanovich
David S. Monson
Robert C. Smith